NYS OPWDD Self-Direction, Individual Directed Goods and Services (IDGS)
SD Mileage Reimbursement Form

This form may be used to reimburse mileage expenses for **service-related activities when transportation is provided in a vehicle owned by:**

(1) a participant who uses his/her own vehicle;
(2) a staff person who uses his/her own vehicle to take a participant for service-related transportation; or
(3) any other person who uses his/her own vehicle to take a participant for service-related transportation.

A separate SD Mileage Reimbursement Form is required for each vehicle owner.

Participant Name: _____ For Month and Year _____

For Vehicle Owned by Participant, Staff or Other

Name of Vehicle Owner: _____

Vehicle owner is (check one): ☐ Participant ☐ Staff ☐ Other

Service-Related Mileage (Transportation must coincide with an approved Plan activity)

Date (mo/day/yr)	Starting Location	Destination	Purpose of Travel	Miles Traveled	Name of Driver
			Total service-related miles traveled for the month:	0	

Total Miles 0 X allowed mileage rate of _____ = _____ $0.00
(staff allowed FI mileage rate)
(all others allowed Federal mileage rate)
Total Requested Reimbursement

The vehicle owner name and signature are only necessary if the vehicle owner will be reimbursed for the mileage. The Self-Direction participant or his/her designee must sign in all cases. That signature will verify that mileage information is accurate.

Signing and submitting false information may lead to a charge of Medicaid fraud.

Self Direction Particpant:

I certify that the travel shown above was necessary in order for me to receive the identified services and/or supports from my Self Direction Plan.

_____ _____
Signature of Participant/Designee (required) Date (mo/day/yr) (required)

Vehicle Owner:

I certify that I provided this transportation using my own vehicle.

_____ _____
Signature of vehicle owner seeking mileage reimbursement Date (mo/day/yr) (required)

Participant: Original to FI