

221 BROADWAY, STE 296.
AMITYVIELE, NY 11701
631-789-7373
selfdirection@halonesworkino.com

Self Hired Support Staff Expense Report

For the Mon	ith of:	Participant's	Participant's Name:			
Check Payo	able To:					
Address:						
	ONE MONTH	H PER EXPENSE REPO	RT			
DATE	ACTIVITY	BUDGET CATEGORY	EXPENSE AMOUNT	APPROVED AMOUNT FOR OFFICE USE ONLY		
	MILEAGE	IDGS				
-	STAFF ACTIVITIES: MEAL	OTPS				
	STAFF ACTIVITIES: TICKETS	OTPS				
	STAFF ACTIVITIES: TRAIN TICKETS	OTPS				
	STAFF ACTIVITIES; PARKING TICKETS	OTPS				
L		TOTAL				
	st that the documented expenses incu	rred were provide	d for the partic	ipant noted above Date		
,				34.0		
Signature of I	ignature of Participant/ Designee			Date		
	FOR OFF	ICE USE OI	NLY			
TOTAL PAID	FOR OTPS	TOTAL PA	ID FOR IDGS			
TOTAL PAID						
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推动事 PM 26/09 TR 1045 STATT EN MILES 21129 21142 4.5 Regular Fare

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Register: 3 8/17/09 Order # 190 1:43PM 46800 1 Santa Fe Chix 8,50 Combo 3.50 SUBTOTAL 12.00 Tax 1.64

CUSTOMER COPY

Date/Time: 2009-08-29 10:32 AM MYC DEA EL#1371013 EHASO#147238

Jashier: Dale

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OFFICE SUPPLY HUT

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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:		Far Mon	th 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 app	roved Plan activity)			
Date (mo/day/yr) Starting Location	Destination	Purpose	of Travel	Miles to Traveled	Name of Driver	
			···			
			· · · · · · · · · · · · · · · · · · ·			
		service-related miles t	raveled for the month:	0		
X	allowed mileage				-	
Total Miles 0	rate of	= ed El mileago rate)		T-4-1 D	\$0.00	
(staff allowed FI mileage rate) Total Requested Reimbursement (all others allowed Federal mileage rate)						
The vehicle owner name and signatur or his/her designee must sign in all c	e are only necessary if the are only necessary if the ases. That signature will	he vehicle owner will be I verify that mileage info	reimbursed for the mile rmation is accurate.	age. The Sel	f-Direction participant	
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 Seif 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 vahida ayyaa aa tii	miles as asia-t-	L	~			
Signature of vehicle owner seeking Participant: Original to FI	mileage reimbursement	τ	Date (mo/d	day/yr)	(required)	