## Department of Intellectual and Developmental Disabilities

# Transportation

**Please write legibly – thank you**

**Month/Year** _____

Travel for the approved recipient will be reimbursed at either the state or agency mileage, whichever is lower. This form is used for travel for medical or nonmedical appointments (day services and other related activities).

*Mileage – The amount will be calculated by the agency staff utilizing point to point mileage.*
*Meals – Receipts for the recipient are required.*
*Lodging – Receipts for the recipient are required.*

Recipient's Name: _____ County: _____

| Date | Place Left | Time Left AM/ PM | Place Arrived | Arrival Time AM/PM | Miles | Amt * | Lodging | Breakfast | Lunch | Dinner | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
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**GRAND TOTAL** _____

By signing and dating this Transportation Form, I, the person supported or legal representative, indicate that all of the information above is correct.

_____ _____

Signature of Person Supported or Legal Representative Date

***All recipients of the Family Support Program sign an annual Service Plan with the agency.***
***The Service Plan documents the service and amount approved for the year.***
***This Reimbursement Form is to reimburse you for the approved travel.***

*DIDD-5199*

*RDA Pending*

**Please write all addresses of the places you travel to – I need the addresses to verify the mileage amounts.**

022019