Auglaize DD
County Board of Developmental Disabilities
empower • include • achieve

FSS Mileage
Reimbursement Form

Individuals Name: _____

Name of Parent/Guardian, Family Member Residing with: _____

Address of Parent/Guardian: _____

Date	Beginning Mileage	Ending Mileage	Total Miles	Rate Pd. Per Mile	Total Paid	To / From
				0.725		
				0.725		
				0.725		
				0.725		
				0.725		
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				0.725		
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				0.725		
				0.725		
				0.725		
				0.725		
				0.725		
Total						

I hereby certify that the above is an accurate statement of mileage incurred.

Signature of Parent/Guardian
or Family Member Residing with _____ Date _____

**** This form must be attached to the Auglaize DD FSS Reimbursement Request Form****