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
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
				0.560	$0.00	
Total					$0.00	

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****