MCFI Home Care Field Staff Prior Authorized Mileage Reimbursement

Employee Name: _____ Client Name: _____

Pay Period: _____

Fill out completely and submit with timecard for client within the same pay period.

Date	Address/Location Name TO/FROM	Purpose of Trip	Client in Vehicle	Miles	Client in Vehicle
			Yes or No		Yes or No
			Yes or No		Yes or No
			Yes or No		Yes or No
			Yes or No		Yes or No
			Yes or No		Yes or No
			Yes or No		Yes or No
			Yes or No		Yes or No
			Yes or No		Yes or No
			Yes or No		Yes or No
			Yes or No		Yes or No
			Total Mileage:	0	

Mileage listed was the shortest distance between destinations and was incurred during company time. I adhere to all procedures with the driving policy, such as valid DL, valid insurance as required by WI State Law, and I have ensured the safety practices while driving on company time.

Employee Signature: _____ Date: _____

CCC Authorization:

I have reviewed this request and authorize this employee to be reimbursed for the mileage in the amount of:

Mileage reimbursement rate: _____**0.4** X # of Miles_____=_____

Prior authorization check verification: _____

CCC /TL Signature: _____ Date: _____

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