

Human Resources Center ~ Transportation Invoice - September 2023

MPI# 100000783 Location Code: 0011

Name: _____

Individual Name: _____

Employee:

Primary Caregiver:

Address & Telephone: _____

Rate: \$0.63 Eff: July 2022

Office Use Only

DAY	DATE	LOCATION	ADDRESS	LOCATION	ADDRESS	REASON	MILEAGE	DAILY TOTAL	TRIP MILEAGE	
									Plan	Non-Plan
FRI	1									
FRI	1									
SAT	2									
SAT	2									
WEEK TOTAL:										
SUN	3									
SUN	3									
MON	4									
MON	4									
TUE	5									
TUE	5									
WED	6									
WED	6									
THU	7									
THU	7									
FRI	8									
FRI	8									
SAT	9									
SAT	9									
WEEK TOTAL:										
SUN	10									
SUN	10									
MON	11									
MON	11									
TUE	12									
TUE	12									
WED	13									
WED	13									
THU	14									
THU	14									
FRI	15									
FRI	15									
SAT	16									
SAT	16									
WEEK TOTAL:										

Office Use Only

Plan Miles: _____ Non-Plan Miles: _____ Total Miles: _____

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Name: _____

Individual Name: _____

Employee:

Primary Caregiver:

DAY	DATE	LOCATION	ADDRESS	LOCATION	ADDRESS	REASON	MILEAGE	TRIP MILEAGE			
								DAILY TOTAL	Plan	Non-Plan	
SUN	17										
SUN	17										
MON	18										
MON	18										
TUE	19										
TUE	19										
WED	20										
WED	20										
THU	21										
THU	21										
FRI	22										
FRI	22										
SAT	23										
SAT	23										
WEEK TOTAL:											
SUN	24										
SUN	24										
MON	25										
MON	25										
TUE	26										
TUE	26										
WED	27										
WED	27										
THU	28										
THU	28										
FRI	29										
FRI	29										
SAT	30										
SAT	30										
WEEK TOTAL:											

I verify that miles submitted are in compliance with the authorized Individual Support Plan and that I am in compliance with all waiver requirements. Any mileage submitted that are **not** consistent with the authorized Individual Support Plan will not be processed

Signature: _____ Date: _____ Approved by - _____ Date: _____

Relationship to Consumer: _____

(Invoices must be **approved/verified by the Consumer himself/herself, or Primary Caretaker **before** it is submitted for payment. Invoices that are not signed cannot be paid.)

Signed invoices must be received in our office by the Third (3rd) of each month : fax to: (570) 872-9959

Human Resources Center, Inc.

PO Box 77, Effort PA 18330