Human Resources Center ~ Transportation Invoice - December 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:					

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*Plan Miles:*______________ *Non-Plan Miles:*______________ ***Total Miles*** *:*______________

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DAY	DATE	LOCATION	ADDRESS	LOCATION	ADDRESS	REASON	MILEAGE	DAILY TOTAL	TRIP MILEAGE Plan	TRIP MILEAGE 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:				
SUN	31									
SUN	31									

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