Swissport
2150 SMITHTOWN AVE, SUITE 4, RONKONKOMA, NY 11779
Phone 516-433-4500
-MILEAGE REIMBURSEMENT PROGRAM-

Notification Date: _____

Child's Name: _____
Address: _____

_____

Dear Parent/Guardian:

Welcome to the **Mileage Reimbursement Program (MRP)** for Nassau County. This Mileage Reimbursement packet contains the necessary claim forms and instructions for you to submit your claims.

- When submitting your MR claims please be sure to print all information legibly in **blue ink.** This will help expedite claims for payment.
- Reimbursement will be paid at the Federal rate per mile for one trip to the service provider *and* one trip from the service provider daily (i.e. only one round trip per day).
- The number of miles from a child's legal address to the service provider will be determined by utilizing **MapQuest only. If you do not have internet access, please call Swissport at 631-737-0600 to obtain your MapQuest mileage.**
- Parent/Guardian MUST drive the child on a consistent basis.
- Parent/Guardian MUST have the dates on the Claim Form validated by a Service provider representative.
- Completed claim forms are to be mailed no later that fifteen (15) calendar days after the end of the period for which the claim is being made (for example, the claim form for April – June must be mailed to this office by July 15).
- Complete Nassau County Claim Voucher in **blue ink** (see attached) Must submit a Claim Voucher for each Claim Form.
- Complete Nassau County Request for Taxpayer Form in **blue ink** (#700-W9)
  ***A blank voided check must be attached to the Taxpayer Form if electronic payment is requested.**

If you have any questions, please do not hesitate to contact me at 631-737-0600

Sincerely,

Kathy Stork
Mileage Reimbursement Examiner

CC: Liz Hartley, General Manager, Nassau County Preschool Transportation Services
X:\old\Nassau PMR\PMR-NASSAU 2018 packet letter- 1final.doc

Swissport
2150 SMITHTOWN AVE, SUITE 4, RONKONKOMA, NY 11779
Phone 516-433-4500
-MILEAGE REIMBURSEMENT PROGRAM-

CLAIM FORM INSTRUCTIONS: (Please refer to the enclosed example Claim Form)

Parents/Guardians are responsible for completing SECTIONS A, B & C

SECTION A
- Child's Name
- Legal Address
- Date of Child's Birth
- Name of Service Provider
- Service Provider Location

SECTION B
CIRCLE each date in each month you transported your child to **AND** from the approved Service Provider

SECTION C
Signature of Parent/Guardian
Date of signature
Valid phone number
Legibly print Parent/Guardian name
Social Security Number of Parent/ Guardian claiming reimbursement

Parents/Guardians are responsible for completing SECTIONS 4, 6, 7 & 8 on the Nassau County Claim Voucher

SECTION 4
Parent/Guardian
Social Security Number

SECTION 6
Parent/Guardian Name

SECTION 7
Mailing Address

SECTION 8
Parent/Guardian printed Name, Date completed
Parent/Guardian Signature

Service Provider Representative is responsible for completing SECTIONS D & E

SECTION D
Verify if child is Early Intervention or Preschool
Include EI Authorization Number if applicable
Verify number of authorized days of service/program

SECTION E
CIRCLE each date in each month child attended services/program at Service provider location. School Representative **MUST** sign and date this section.

If you have any questions, please do not hesitate to contact me at 631-737-0600.

Please send the requested documents to the following address:

Swissport
2150 SMITHTOWN AVE, SUITE 4
RONKONKOMA, NY 11779
Attn: Mileage Reimbursement Program

Sincerely,

Kathy Stork
Mileage Reimbursement Examiner

CC: Liz Hartley, General Manager, Nassau County Preschool Transportation Services

NASSAU COUNTY REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

☐ New Vendor OR Change of Existing (Check All That Apply)

☐ Name Change ☐ Add/Change Electronic Remittance Information ☐ Contact Change

☐ Address Change ☐ Add/Change Check Remittance Information ☐ OTHER Change

Section I – Vendor Information (*required)

1. Federal ID No or Social Security No.

2.Vendor Name:

3.Vendor Remittance Address:

4. Vendor Contact Person:

5. Vendor Contact Telephone No.:

6. Vendor E-Mail Address:

7. Please answer the questions below.

A. The vendor/payee ID number provided above is: Federal ID# [ ] Social Security # [ ]

B. Is vendor/payee incorporated: Yes [ ] No [ ]

C. Is a medical or legal service ever provided by vendor: Yes [ ] No[ ]

D. Is vendor/payee an employee of Nassau County: Yes [ ] No [ ]

E. Parent of Child in Early Intervention or Pre-School Special Education Program Yes [ ] No [ ]

Section II -Financial Institution Information-Complete this section only if you would like to be paid electronically.

8a. Routing Transit Number: *(Located at the bottom of your check)*

8b. Routing Transit Number Being Replaced (if applicable):

9a. Bank Account Number:

9b. Bank Account Number Being Replaced (if applicable):

10. Account Name:

11.Bank Name: (8a.)_____

(8b.)_____

12. Please include a VOIDED check or Bank Letter for verification.

Check here [ ] if you wish to be removed from electronic payments and would like to receive paper checks.

14. Vendor Certification: **Certification-Under penalties of perjury, I certify that**: (1) The number shown on this form is my correct identification number (or I am waiting for a number to be issued to me), and (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends or (c) the IRS has notified me that I am no longer subject to backup withholding. (3) The information provided on this form is correct to the best of my knowledge.
Certification Instructions-You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on you tax return. For real estate transactions, item (2) does not apply. The IRS does not require your consent to any provision of this document other than the certification required to avoid backup withholding.
I understand that if I have completed Section II that I authorize payments to be received by electronic funds transfer into the bank account designated in Section II. I further understand that in the event that an erroneous electronic payment is sent, Nassau County reserves the right to reverse the electronic payment, In the event that a reversal cannot be implemented, Nassau County will utilize any other lawful means to retrieve payments to which the payee was not entitled.

Authorized Signature **Print Name/Title** **Date**

[Dept. Use] Form Submitted By: (Name) _____

(NC Department) _____ (Contact #) _____

Office use only; disburse type 2 account type C

COUNTY OF NASSAU

CLAIM VOUCHER

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

① INVOICE NUMBER	DOCUMENT # (FOR NASSAU COUNTY DEPARTMENT USE ONLY)
② ORDER /CONTRACT NO.	③ BLANKET ORDER NO.

④ VENDOR INFORMATION: NUMBER (9) ⑤ SUFFIX (2)

⑥ NAME (30)

(30)

⑦ ADDR (30)

(30)

(30)

DISCOUNT AMOUNT

DISCOUNT DATE MD (2) DY (2) YR (2)

CLAIMANTS CERTIFICATION

I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source.

⑧ Claimants Name — Date

X

By (Signature) — Title

⑨ DEPT. GOODS OR SERVICES DELIVERED TO

⑩ VENDOR'S PAYMENT TERMS

⑪ DATE DELIVERED	ITEMIZATION	UNIT PRICE	AMOUNT
		⑫ TOTAL CLAIMED ▶	

For Nassau County Department Use Only:

NIFS ACCOUNT CODES *Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.*

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
4										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

NC Department _____ Amount Approved $ _____

Contact Person _____ Date _____

Telephone No. _____ Comptrollers Approval _____

FORM NIFS560.11/98 (OCR)

COUNTY OF NASSAU

CLAIM VOUCHER

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

① INVOICE NUMBER	DOCUMENT # _____ *(FOR NASSAU COUNTY DEPARTMENT USE ONLY)*
② ORDER /CONTRACT NO.	③ BLANKET ORDER NO.

VENDOR INFORMATION: NUMBER (9) SUFFIX (2)

④ _____ ⑤ _____

⑥ NAME (30) _____

(30) _____

⑦ ADDR (30) _____

(30) _____

(30) _____

DISCOUNT AMOUNT

DISCOUNT DATE MO (2) DY (2) YR (2)

CLAIMANTS CERTIFICATION

I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source.

⑧ _____ _____

Claimants Name Date

X _____ _____

By (Signature) Title

DEPT. GOODS OR SERVICES DELIVERED TO ⑨ | VENDOR'S PAYMENT TERMS ⑩

⑪ DATE DELIVERED	ITEMIZATION	UNIT PRICE	AMOUNT
		⑫ TOTAL CLAIMED ▶	

For Nassau County Department Use Only:

NIFS ACCOUNT CODES *Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.*

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
4										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

NC Department _____ Amount Approved $ _____

Contact Person _____ Date _____

Telephone No. _____ Comptrollers Approval _____

FORM NIFS55 11/08 2/12

COUNTY OF NASSAU

CLAIM VOUCHER

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

INVOICE NUMBER ①

DOCUMENT # (FOR NASSAU COUNTY DEPARTMENT USE ONLY)

ORDER/CONTRACT NO. ②

BLANKET ORDER NO. ③

VENDOR INFORMATION: NUMBER (9) SUFFIX (2)

④ _____ ⑤ _____

NAME (30) ⑥ _____

(30) _____

ADDR (30) ⑦ _____

(30) _____

(30) _____

DISCOUNT AMOUNT

DISCOUNT DATE MO (2) DY (2) YR (2)

CLAIMANTS CERTIFICATION

I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source.

⑧

Claimants Name _____ Date _____

X

By (Signature) _____ Title _____

DEPT. GOODS OR SERVICES DELIVERED TO ⑨

VENDOR'S PAYMENT TERMS ⑩

⑪ DATE DELIVERED	ITEMIZATION	UNIT PRICE	AMOUNT
		⑫ TOTAL CLAIMED ▶	

For Nassau County Department Use Only:

NIFS ACCOUNT CODES *Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.*

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
4										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

NC Department _____ Amount Approved $ _____

Contact Person _____ Date _____

Telephone No. _____ Comptrollers Approval _____

FORM NIFS560.11/98

COMPTROLLER COPY

CO-155-A.3/98 REV. 10/00

COUNTY OF NASSAU

CLAIM VOUCHER

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

① INVOICE NUMBER

DOCUMENT # _____
(FOR NASSAU COUNTY DEPARTMENT USE ONLY)

② ORDER /CONTRACT NO.

③ BLANKET ORDER NO.

VENDOR INFORMATION: NUMBER (9) SUFFIX (2)

④ _____ ⑤ _____

⑥ NAME (30) _____

(30) _____

⑦ ADDR (30) _____

(30) _____

(30) _____

DISCOUNT AMOUNT

DISCOUNT DATE MO (2) DY (2) YR (2)

CLAIMANTS CERTIFICATION

I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source.

⑧ _____ Date _____
Claimants Name

X _____ Title _____
By (Signature)

DEPT. GOODS OR SERVICES DELIVERED TO ⑨

VENDOR'S PAYMENT TERMS ⑩

⑪ DATE DELIVERED	ITEMIZATION	UNIT PRICE	AMOUNT
		⑫ TOTAL CLAIMED ▶	

For Nassau County Department Use Only:

NIFS ACCOUNT CODES *Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.*

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

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LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

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LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

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LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
4										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - "invoice no. or claim no." description

NC Department _____ Amount Approved $ _____

Contact Person _____ Date _____

Telephone No. _____ Comptrollers Approval _____

FORM NIFS55 11/00 (YELLOW)

NASSAU COUNTY DEPARTMENT OF HEALTH SERVICES - DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT CLAIM FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

Child is: D

☐ Early Intervention (birth-2yrs 11mos)

ADDRESS: _____ A _____ SERVICE PROVIDER: _____ A _____

EI Auth. # _____

SERVICE LOCATION _____

EXAMPLE

☐ Preschool Age (3-5yrs)

NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM: _____

CLAIM PERIOD: July & August SCHOOL YEAR: _____

JULY FOR PARENT/GUARDIAN USE ONLY

B

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31									

FOR SERVICE PROVIDER USE ONLY

E

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31									

Verified by: _____
SCHOOL REPRESENTATIVE DATE

_____
SCHOOL REPRESENTATIVE TITLE (PRINT)

AUG. FOR PARENT/GUARDIAN USE ONLY

B

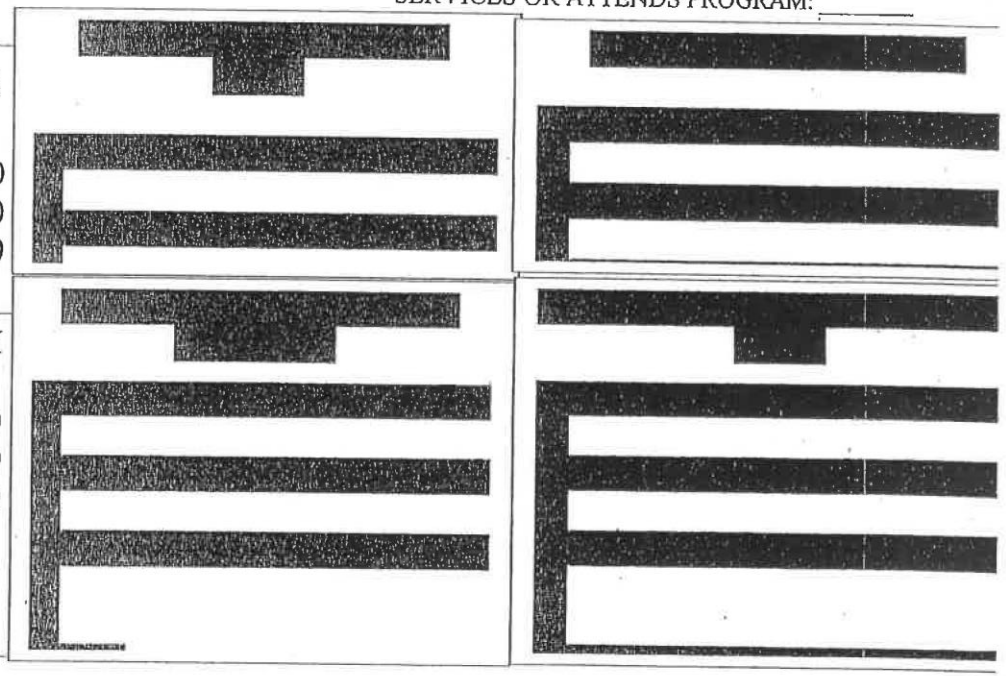
1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31									

FOR SERVICE PROVIDER USE ONLY

E

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31									

Verified by: _____
SCHOOL REPRESENTATIVE DATE



This Form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar days after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to:

TO: NASSAU COUNTY DEPARTMENT OF HEALTH MILEAGE REIMBURSEMENT PROGRAM

Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, NY 11779

C

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian	Date	Telephone #	Printed name of Parent/Guardian	Social Security Number of Parent/Guardian

FOR SWISSPORT USE ONLY

F

_____ X _____ X _____ X 2 = $ _____
one-way mileage # of Days reimbursement rate

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT ATTENDANCE FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SERVICE PROVIDER: _____

_____ SERVICE LOCATION _____

CLAIM PERIOD: Sept. – Dec. SCHOOL YEAR: _____

Child is:
☐ Early Intervention (birth-2yrs 11mos)
EI Auth. # _____
☐ Preschool Age (3-5yrs)
NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM: _____

SEPT. FOR PARENT/GUARDIAN USE ONLY	OCT. FOR PARENT/GUARDIAN USE ONLY	NOV. FOR PARENT/GUARDIAN USE ONLY	DEC. FOR PARENT/GUARDIAN US ONLY
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 1 11 12 13 14 15 16 17 18 19 2 21 22 23 24 25 26 27 28 29 3 31
FOR SERVICE PROVIDER USE ONLY	**FOR SERVICE PROVIDER USE ONLY**	**FOR SERVICE PROVIDER USE ONLY**	**FOR SERVICE PROVIDER US ONLY**
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 1 11 12 13 14 15 16 17 18 19 2 21 22 23 24 25 26 27 28 29 3 31
Verified by: _____ SCHOOL REPRESENTATIVE DATE _____ SCHOOL REPRESENTATIVE TITLE (PRINT)	Verified by: _____ SCHOOL REPRESENTATIVE DATE _____ SCHOOL REPRESENTATIVE TITLE (PRINT)	Verified by: _____ SCHOOL REPRESENTATIVE DATE _____ SCHOOL REPRESENTATIVE TITLE (PRINT)	Verified by: _____ SCHOOL REPRESENTATIVE DAT _____ SCHOOL REPRESENTATIVE TITLE (PRINT)

This Form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar d after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to: **Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, Ny 11779**
RE: NASSAU COUNTY DEPARTMENT OF HEALTH MILEAGE REIMBURSEMENT PROGRAM

I certify that I provided transportation for the above named child on the dates indicated

Signature of Parent/Guardian	Date	Telephone #	Printed name of Parent/Guardian	Social Security Number of Parent/Guardian

FOR SWISSPORT USE ONLY _____ X _____ X _____ X 2 = $ _____
one-way mileage # of Days reimbursement rate

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT ATTENDANCE FORM

CHILD'S NAME: ______________ DATE OF BIRTH: ______________

ADDRESS: ______________ SERVICE PROVIDER: ______________

______________ SERVICE LOCATION ______________

CLAIM PERIOD: January – March SCHOOL YEAR: ________

Child is:
☐ Early Intervention (birth-2yrs 11mos)
EI Auth. # ______________
☐ Preschool Age (3-5yrs)

NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM: ________

JAN. FOR PARENT/GUARDIAN USE ONLY	FEB. FOR PARENT/GUARDIAN USE ONLY	MAR. FOR PARENT/GUARDIAN USE ONLY	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	[redacted]
FOR SERVICE PROVIDER USE ONLY	FOR SERVICE PROVIDER USE ONLY	FOR SERVICE PROVIDER USE ONLY	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	[redacted]
Verified by: ______________ SCHOOL REPRESENTATIVE DATE	Verified by: ______________ SCHOOL REPRESENTATIVE DATE	Verified by: ______________ SCHOOL REPRESENTATIVE DATE	
SCHOOL REPRESENTATIVE TITLE (PRINT)	SCHOOL REPRESENTATIVE TITLE (PRINT)	SCHOOL REPRESENTATIVE TITLE (PRINT)	

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RE: NASSAU COUNTY DEPARTMENT OF HEALTH MILEAGE REIMBURSEMENT PROGRAM

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian	Date	Telephone #	Printed name of Parent/Guardian	Social Security Number of Parent/Guardian

FOR SWISSPORT USE ONLY ________ X ________ X ________ X 2 = $ ________
one-way mileage # of Days reimbursement rate

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT ATTENDANCE FORM

CHILD'S NAME: ______________________ DATE OF BIRTH: ______________

ADDRESS: ______________________ SERVICE PROVIDER: ______________

______________________ SERVICE LOCATION ______________

CLAIM PERIOD: April - June SCHOOL YEAR: __________ ______________

Child is:
☐ Early Intervention (birth-2yrs 11mos)
EI Auth. # ______________
☐ Preschool Age (3-5yrs)

NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM: _______

APRIL. FOR PARENT/GUARDIAN USE ONLY	MAY FOR PARENT/GUARDIAN USE ONLY	JUNE FOR PARENT/GUARDIAN USE ONLY	[redacted]
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	
FOR SERVICE PROVIDER USE ONLY	FOR SERVICE PROVIDER USE ONLY	FOR SERVICE PROVIDER USE ONLY	[redacted]
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	
Verified by: ____________ SCHOOL REPRESENTATIVE DATE ____________ SCHOOL REPRESENTATIVE TITLE (PRINT)	Verified by: ____________ SCHOOL REPRESENTATIVE DATE ____________ SCHOOL REPRESENTATIVE TITLE (PRINT)	Verified by: ____________ SCHOOL REPRESENTATIVE DATE ____________ SCHOOL REPRESENTATIVE TITLE (PRINT)	

This Form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar d after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to **Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, Ny 11779**
RE: NASSAU COUNTY DEPARTMENT OF HEALTH MILEAGE REIMBURSEMENT PROGRAM

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian	Date	Telephone #	Printed name of Parent/Guardian	Social Security Number of Parent/Guardian

FOR SWISSPORT USE ONLY ________ X ________ X ________ X 2 = $ ________
one-way mileage # of Days reimbursement rate

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS
MILEAGE REIMBURSEMENT ATTENDANCE FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SERVICE PROVIDER: _____

_____ SERVICE LOCATION _____

CLAIM PERIOD: July & August SCHOOL YEAR: _____

Child is:
☐ Early Intervention (birth-2yrs 11mos)
EI Auth. # _____
☐ Preschool Age (3-5yrs)
NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM: _____

JULY FOR PARENT/GUARDIAN USE ONLY	AUG. FOR PARENT/GUARDIAN USE ONLY	[redacted]	[redacted]
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31		
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