

Family Support Services Program (FSSP)

Respite and Mileage Reimbursement Form

Individual/Family on FSSP:	
Member Medicaid ID or SSN:	
Make Payment To:	
Payment Address:	

RESPITE CARE:

Name of Respite Provider: _____

Date:	Start Time:	End Time:	Amount Paid:
			\$
			\$
			\$
			\$
			\$
			\$
Total Amount Paid			\$

Purpose of respite care: _____

MILEAGE REIMBURSEMENT: *If you are covered by Medicaid, you must pursue mileage reimbursement through Medicaid prior to using FSSP funds.*

Have you attempted reimbursement through Medicaid: Yes ☐ No ☐ Not eligible ☐

If yes, what was the outcome: _____

If no, what was the reason: _____

Date:	Start Location:	End Location:	Trip Miles:
Total Miles			
Total Miles x \$0.48 =			\$

Purpose of trip: _____

CONFIRM: By signing my name below, I confirm that the information above is correct.

Family Member's Signature: _____ Date: _____