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

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 <u>blue ink.</u> This will help expedite claims for payment.
- Reimbursement will be paid at the Federal rate per mile for <u>one trip to the service provider and one</u> 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 <u>blue ink</u> (see attached) Must submit a Claim Voucher for each Claim Form.
- Complete Nassau County Request for Taxpayer Form in <u>blue ink</u> (#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

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

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

<u>SECTION 6</u> 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

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3.Vendor	Remittance Address:								
4. Vendor	Contact Person:								
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		D Pres	Preschool Age (3-5yrs)
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I certify	C / that I provided transportation for the	C I certify that I provided transportation for the above named child on the dates indicated.	ated.
Signature of Parent/Guardian	Date Telephone#	Printed name of Parent/Guardian	Social Security Number of Parent/Guardian
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s I certif	y that I provided transportation for tl	I certify that I provided transportation for the above named child on the dates indicated	icated

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Signature of Parent/Guardian

Social Security Number of Parent/Guardian

Printed name of Parent/Guardian

Telephone #

Date

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NASSAU COUNTY DEPARTMENT OF HEALTH

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one-way mileage # of Days reimbursement rate

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2	OFFICE OF SERVICES FOR CI MILEAGE REIMBURSEN	OFFICE OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS MILEAGE REIMBURSEMENT ATTENDANCE FORM	
CHILD'S NAME:	DATE OF BIRTH:	Child is:	5
ADDRESS:	SERVICE PROVIDER:	DEarly L	□ Early Intervention (birth-2yrs 11mos)
	SERVICE LOCATION	EI Auth. #	
		D Presch	Preschool Age (3-5yrs)
CLAIM PERIOD: April - June SCHOOL YEAR:		NUMBER (NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM:
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SCHOOL REPRESENTATIVE TITLE (PRINT)	SCHOOL REPRESENTATIVE TITLE (PRINT)	SCHOOL REPRESENTATIVE TITLE (PRINT)	
This Form will be rejected without the verified attendance portion above completed by the Service Provider Representative. after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form RE: NASSAU COUNTY DEPARTMENT OF HEALTH MILEAGE REIMBURSEMENT PROGRAM	ttendance portion above completed by the Serv being made. Forward this completed Mileage. 7 HEALTH MILEAGE REIMBURSEMEN	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 c 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	Claims should be submitted no later than fifteen (15) calendar of Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, Ny 11779
I certify	⁄ that I provided transportation for t	I certify that I provided transportation for the above named child on the dates indicated.	licated.
Signature of Ravent/Guardian	Date Telephone#	Printed name of Parent/Guardian	Social Security Number of Parent/Guardian

Signature of Parent/Guardian

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one-way mileage # of Days reimbursement rate

Social Security Number of Parent/Guardian

	OFFICE OF SERVICES FOR CH MILEAGE REIMBURSEM	NASSAU COUNTY DEPARTMENT OF HEALTH OFFICE OF SERVICES FOR CHILDREN WITH SPECIAL NEEDS MILEAGE REIMBURSEMENT ATTENDANCE FORM	-
:HILD'S NAME:	DATE OF BIRTH:	Child is:	
DDRESS:	SERVICE PROVIDER:	EI Auth. #	El Auth. #
	SERVICE LOCATION	D Prese	🗇 Preschool Age (3-5yrs)
JLAIM PERIOD: July & August SCHOOL YEAR:		NUMBER	NUMBER OF DAYS PER WEEK CHILD RECEIVES SERVICES OR ATTENDS PROGRAM:
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I certif	I certify that I provided transportation for the above named child on the dates indicated.	he above named child on the dates in	dicated.
Signature of Parent/Guardian	. Date Telephone #	Printed name of Parent/Guardian	Social Security Number of Parent/Guardian
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