The Arc

For people with intellectual and developmental disabilities

AGENCY WITH CHOICE

Mileage Reimbursement Sheet

Franklin & Fulton Counties
2314 Philadelphia Avenue
Chambersburg, PA 17202
Main Line: 717-264-4390
Fax: 717-264-4390
www.thearcoffranklinfultoncounties.com

Name of Employee: _____ Name of Consumer: _____

Pay Period: ____/____/____ to ____/____/____

	Date	Leave Time	Arrival Time	Odometer Out	Odometer In	Total Mileage	Departure Point Return Point	Destinations: All Places Visited	Managing Employer Sign
1		:	:				_____		
2		:	:				_____		
3		:	:				_____		
4		:	:				_____		
5		:	:				_____		
6		:	:				_____		
7		:	:				_____		
8		:	:				_____		
9		:	:				_____		
10		:	:				_____		
11		:	:				_____		
12		:	:				_____		
13		:	:				_____		
14		:	:				_____		
	Total Miles x $.57								

My signature certifies that I received/provided a service on the date(s) listed above. I understand that payment for these services will be from federal and state funds, and that any false claims, statements, documents, or concealment of material facts may be prosecuted under Federal and State Laws.

Signature of Employee: _____ Date _____

The completed form must be returned to The Arc by mail or by fax according to the bi-weekly payroll schedule. **(Some exceptions may apply: holidays.)** Paychecks will be available based on the Payroll schedule. If you have questions or concerns, please contact The Arc office

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Employee Service Log

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Name of Employee: _____ Name of Consumer: _____

Pay Period: ____/____/____ to ____/____/____

Date of Service	Type of Service (In-home or out)	Hours of Service	Total Hours	Managing Employer Signature
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____

(Rate of pay) (Agency Rate- Office use only)

Total Hours of Service: _____ X _____ = _____ Total Hours of Service: _____ X _____ = _____

My signature certifies that I received/provided a service on the date(s) listed above. I understand that payment for these services will be from federal and state funds, and that any false claims, statements, documents, or concealment of material facts may be prosecuted under Federal and State Laws.

Signature of Employee: _____ Date _____

The completed form must be returned to The Arc by mail or by fax according to the bi-weekly payroll schedule. (**Some exceptions apply: holidays, due date falls on a Saturday or Sunday**) Paychecks will be available based on the Payroll schedule. If you have questions or concerns, please contact The Arc office.