agingnext Ride-and-Go
MILEAGE REIMBURSEMENT

141 Spring St, Claremont, 91711
FAX: 909-741-7296
EMAIL: rideandgo@agingnext.org

RIDERS NAME: _____ CITY OF RESIDENCE: _____ MONTH OF TRAVEL: _____ YEAR: _____

DATE	LIST ALL REASONS FOR TRAVEL LIST ONLY THE NUMBER(S)	STARTING CITY	FULL ADDRESS TO FARTHEST CITY	Total Miles (Roundtrip /ALL Trips)	Driver Print Name: _____ and signatures below	TOTAL DRIVE TIME ROUND 1/4 HR

REASONS: 1= Medical 2=Personal Errands 3=Shopping 4=Visit Family/Religious 5=Dining/Recreation
6= Other (please specify)_____

➔ **MILEAGE FORMS MUST BE RECEIVED NO LATER THAN THE 5TH DAY OF THE NEXT MONTH**

I certify that all information provided is true and accurate. I understand and agree that AgingNext and its funding sources do not assume any liability for my personal safety nor have any insurance liability. I agree to abide by AgingNext policies as signed by myself in the program application. IT IS MY RESPONSIBILITY TO PAY DRIVERS FOR THEIR REPORTED MILEAGE. I understand that if I fail to do so, I may be removed from the program.

RIDER SIGNATURE: _____ DATE: _____

Office use only **Office use only** **Office use only**

Date Received: _____ Miles: _____ Check Amount: $ _____ LA EXP ☐ SB ☐