MILEAGE REIMBURSEMENT FORM
SAN BENITO COUNTY
1111 SAN FELIPE RD. #206, HOLLISTER, CA 95023

PARTICIPANT NAME: _______________________________ SOCIAL SECURITY #: ___________________
COUNSELOR NAME: ________________________________

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<th>DATE</th>
<th>BEGINNING POINT</th>
<th>DESTINATION</th>
<th>PURPOSE</th>
<th>START MILE</th>
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<th>MILES PER TRIP</th>
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PLEASE NOTE: Claims for mileage reimbursement that occurred more than 100 days prior to this claim WILL NOT be accepted.

PLEASE ALLOW  7-14 business days for reimbursement

Signed under Penalty of Perjury

___________________________________   ___________________________________
Signature     Date

*****************************************************************************************************************************************
Component: ___________________________ Actual Miles: ____________ Amount Paid: _____________
Date paid: ___________________________ Initials: ________________