N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING REHABILITATION

TRAVEL REIMBURSEMENT FOR MINI CENTER INSTRUCTORS

For the Period _____ to _____ 20_____

_____ _____
Authorization Number County

Day of Month	Mileage or Cost
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
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23	
24	
25	
26	
27	
28	
29	
30	
31	

_____
Mini Center Instructor's Name (Print or Type)

_____
Social Security No. (**Last 4 Digits Only**)

_____
Address

_____ _____
City State

_____
Zip Code

Miles Driven _____ at $_____ Reimbursement Total: $_____

☐ Non-mileage Reimbursement

Under penalties of perjury I certify this to be a true and accurate statement of vehicle mileage and/or an accurate representation of non-mileage actual costs incurred.

_____ _____
Signature of Mini Center Instructor Date

_____ _____
Counselor Initials Date

_____ _____
Payment Start Date Payment End Date / Invoice Date

_____
Consumer

Original and Copy to Business Affairs and Copy to Counselor.

Business Affairs Mails Copy to Mini Center Instructor with Check.