CADDO VETERAN DIRECTED HCBS
TEXAS
TRAVEL REIMBURSEMENT LOG

Direct Care Worker Name: _____

Veteran Name: _____

Employer Name: _____

Date	Purpose	From	To	Mileage
			Total Miles:	

By signing this form, I certify that my vehicle is safe for transport and that I have a valid driver's license and insurance.

Veteran Signature/Authorized Representative: _____ Date: _____

Direct Care Worker Signature: _____ Date: _____

Mileage Log Submission:

Mail
10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email
Enrollment@Resilient-SD.com