Self Directed Transportation Log

SD Community Habilitation Agency: **Center for Family Support (CFS) Self-Direct Supports**	
Participant's Medicaid CIN:	Participant's Name:

Valued Outcomes: (Enter the participant's valued outcomes and the supports and services associated with each outcome.)

Date: M/D/Y	Valued Outcome and Goal	IDGS or OTPS Transportation	Total Miles/ Cab expense	Total Mertocard Fare	Travel to and Travel From Location

*****Signing and submitting false information may lead to a charge of Medicaid fraud.*****

Signature of Employee: Initials: Date:

Signature of Participant/Representative: Date:

Participant: Original to FI

For FIS Use Only ----- Payroll Authorization **(FI Initials) ……………. (Date)** Total Hours Paid …………….. Total Hours PTO ………………….