SWISSPORT

2150 SMITHTOWN AVE, SUITE 4, RONKONKOMA, NY 11779 Phone 516-433-4500

PARENT MILEAGE REIMBURSEMENT PROGRAM

Date:	Child's Name:
	Adress:

Dear Parent/Guardian:

Welcome to the Parent Mileage Reimbursement Program for Nassau County. This Mileage Reimbursement packet contains the necessary claim forms and instructions for submitting your claims.

- When submitting your PMR claims, please <u>print all information clearly</u>. This will help expedite claims for payment.
- Reimbursement will be paid at the Federal rate per mile for one trip to **and** one trip from the service provider daily (i.e., only one round trip per day).
- The number of miles from a child's legal address to the service provider will be determined by utilizing MapQuest only, which Swissport will calculate.
- Parent/Guardian MUST drive the child on a consistent basis.
- Parent/Guardian MUST have the dates on the Mileage Reimbursement Attendance Form validated by a Service provider representative.
- Only the authorized Parent is permitted to fill out the Parent Mileage Reimbursement forms.
- Complete Nassau County Claim Vouchers (see attached). You MUST submit a Claim Voucher for each Mileage Reimbursement Attendance Form.
- Complete Nassau County Request for Taxpayer Form (#700-W9 Revised October 2019):
 - **A blank voided check must be attached to the Taxpayer Form if electronic payment (direct deposit) is requested. The Taxpayer Form only needs to be submitted once, unless any bank changes are made.
- Completed Claim Voucher forms are to be mailed no later than fifteen (15) calendar days after the end of the period for which the claim is being made (for example, the Claim Voucher form for April-June must be mailed to this office by July 15).

If you have any questions, please do not hesitate to contact Swissport at 516-433-4500 or 631-737-0600.

Sincerely,

Swissport Mileage Reimbursement Examiners

SWISSPORT

2150 SMITHTOWN AVE, SUITE 4, RONKONKOMA, NY 11779 Phone 516-433-4500

PARENT MILEAGE REIMBURSEMENT PROGRAM

INSTRUCTIONS FOR ALL FORMS: MILEAGE REIMBURSEMENT ATTENDANCE FORM (Submitted Quarterly)

TOP SECTION	MIDDLE SECTION	BOTTOM SECTION
-Child's Name	Circle each date in each month you	-Signature of Parent/Guardian
-Legal Address	transported your child to and from	-Date of Signature
-Child's Date of Birth	the approved Service Provider. The	-Valid Phone Number
-Name of Service Provider	Service Provider must circle dates,	-Legibly Printed Parent/Guardian
-Service Provider Location	print, and sign their section.	Name
-Check Early Intervention or		-Social Security Number of Parent
Preschool		Claiming Reimbursement

COUNTY OF NASSAU CLAIM VOUCHER FORM (Submitted Quarterly)

Parents/Guardians are responsible for completing SECTIONS 4,6,7 & 8 on the Nassau County Claim Voucher

SECTION 4	SECTION 6	SECTION 7	SECTION 8
Parent/Guardian	Parent/Guardian Name	Mailing Address	Legibly printed
Social Security Number			Parent/Guardian name
			and sign

^{**} Please fill out 4,6,7 & 8 only. Failure to do so will cause claim to be returned, unprocessed and will cause a delay in your reimbursement. **

NASSAU COUNTY REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION FORM

(Submitted once unless information changes)

·	.
SECTION I-VENDOR INFORMATION	SECTION II-FINANCIAL INSTITUTION INFORMATION
*(PARENT CLAIMING REIMBURSEMENT IS THE	If you would like to be paid electronically (DIRECT
VENDOR)	DEPOSIT), fill out this section and include a Voided
Fill out numbers 1 through 7.	Check.
#12 – Check box if you would prefer to receive a	
paper check.	
#14 – Sign, Print and Date form.	

Please include all three forms when submitting. Taxpayer form should only be submitted once. Mileage Reimbursement attendance form must always be accompanied with a claim voucher form.

If you have any questions, please do not hesitate to contact Luz or Brigid at 516-433-4500 or 631-737-0600.

Please send the requested documents to the following address:

Swissport 2150 SMITHTOWN AVE, SUITE 4 RONKONKOMA, NY 11779

Attn: Mileage Reimbursement Program

MILEAGE REIMBURSEMENT ATTENDANCE FORM OFFICE FOR CHILDREN WITH SPECIAL NEEDS NASSAU COUNTY DEPARTMENT OF HEALTH

CHILD'S NAME:	DATE OF BIRTH:	CHILD IS:	
ADDRESS:	SERVICE PROVIDER:	Early Inte	\square Early Intervention (Birth to 2yrs & 11 mos.)
	SERVICE LOCATION:	El Auth. #:	
		□ Preschoo	□Preschool Age (3 – 5 years)
CLAIM PERIOD: Sep – Dec	SCHOOL YEAR:	NUMBER O	NUMBER OF DAYS PER WEEK CHILD RECEIVES
		SERVICES O	SERVICES OR ATTENDS PROGRAM:
SEP FOR PARENT/GUARDIAN USE	OCT FOR PARENT/GUARDIAN USE	NOV FOR PARENT/GUARDIAN USE	DEC FOR PARENT/GUARDIAN USE
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31	31	31	31
Verified by:	Verified by:	Verified by:	Verified by:
SCHOOL REPRESENTATIVE DATE	SCHOOL REPRESENTATIVE DATE	SCHOOL REPRESENTATIVE DATE	SCHOOL REPRESENTATIVE DATE

This form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar days after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to: Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, NY 11779.

(PRINT)

SCHOOL REPRESENTATIVE TITLE

(PRINT)

SCHOOL REPRESENTATIVE TITLE

(PRINT)

SCHOOL REPRESENTATIVE TITLE

(PRINT)

SCHOOL REPRESENTATIVE TITLE

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian	Date		Phone Number	Printed Name of Parent/Guardian	Social Security # of Parent/Guardian
FOR SWISSPORT USE ONLY	One-Way Mileage	X # of Days	X Reimbursement Rate	X 2= 5	

NASSAU COUNTY DEPARTMENT OF HEALTH OFFICE FOR CHILDREN WITH SPECIAL NEEDS MILEAGE REIMBURSEMENT ATTENDANCE FORM

CHILD'S NAME:	DATE OF BIRTH:	CHILD IS:
ADDRESS:	SERVICE PROVIDER:	☐ Early Intervention (Birth to 2yrs & 11 mos.)
	SERVICE LOCATION:	El Auth. #:
		☐ Preschool Age (3 – 5 years)
CLAIM PERIOD: Jan – Mar	SCHOOL YEAR:	NUMBER OF DAYS PER WEEK CHILD RECEIVES
		SERVICES OR ATTENDS PROGRAM:

JAN FOR PARENT/GUARDIAN USE	FEB FOR PARENT/GUARDIAN USE	MAR FOR PARENT/GUARDIAN USE
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FOR SERVICE PROVIDER USE ONLY	FOR SERVICE PROVIDER USE ONLY	FOR SERVICE PROVIDER USE ONLY
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22 23 24 25 26 27 28 29 30	21 22 23 24 25 26 27 28 29 30	21 22 23 24 25 26 27 28 29 30
	31	31
Verified by:	Verified by:	Verified by:
SCHOOL REPRESENTATIVE DATE	SCHOOL REPRESENTATIVE DATE	SCHOOL REPRESENTATIVE DATE
SCHOOL REPRESENTATIVE TITLE (PRINT)	SCHOOL REPRESENTATIVE TITLE (PRINT)	SCHOOL REPRESENTATIVE TITLE (PRINT)

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Leertify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian	Date		Phone Number	Printed Name of Parent/Guardian	Social Security # of Parent/Guardian
FOR SWISSPORT USE ONLY		×	XX2=\$_	\$	
	One-Way Mileage	# of Days	Reimbursement Rate		

NASSAU COUNTY DEPARTMENT OF HEALTH OFFICE FOR CHILDREN WITH SPECIAL NEEDS MILEAGE REIMBURSEMENT ATTENDANCE FORM

CHILD'S NAME:	DATE OF BIRTH:	CHILD IS:
ADDRESS:	SERVICE PROVIDER:	\square Early Intervention (Birth to 2yrs & 11 mos.)
	SERVICE LOCATION:	El Auth. #:
		☐ Preschool Age (3 — 5 years)
CLAIM PERIOD: Apr – June	SCHOOL YEAR:	NUMBER OF DAYS PER WEEK CHILD RECEIVES
		SERVICES OR ATTENDS DROGRAM:

JUNE FOR PARENT/GUARDIAN USE	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	31 EOR SERVICE DROWINER LISE ONLY	1 2 3 4 5 6 7 8 9 10	11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	ATIVE	SCHOOL REPRESENTATIVE TITLE (PRINT)
MAY FOR PARENT/GUARDIAN USE ONLY	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	31 FOR SERVICE DROVIDER LISE ONLY	1 2 3 4 5 6 7 8 9 10	11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	TIVE	SCHOOL REPRESENTATIVE TITLE (PRINT)
APR FOR PARENT/GUARDIAN USE ONLY	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	31 EOR SERVICE DROWIDER LISE ONLY	1 2 3 4 5 6 7 8 9 10	11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	ITINE	SCHOOL REPRESENTATIVE TITLE (PRINT)

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I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian	Date		Phone Number	Printed Name of Parent/Guardian	Social Security # of Parent/Guardian
FOR SWISSPORT USE ONLY		×	_ X X 2= \$		
	One-Way Mileage	# of Days	Reimbursement Rate		

NASSAU COUNTY DEPARTMENT OF HEALTH OFFICE FOR CHILDREN WITH SPECIAL NEEDS MILEAGE REIMBURSEMENT ATTENDANCE FORM

CHILD'S NAME:	DATE OF BIRTH:	CHILD IS:
ADDRESS:	SERVICE PROVIDER:	☐ Early Intervention (Birth to 2yrs & 11 mos.)
	SERVICE LOCATION:	El Auth. #:
		☐ Preschool Age (3 – 5 years)
CLAIM PERIOD: July – Aug	SCHOOL YEAR:	NUMBER OF DAYS PER WEEK CHILD RECEIVES
		SERVICES OR ATTENDS PROGRAM:

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This form will be rejected without the verified attendance portion above completed by the Service Provider Representative. Claims should be submitted no later than fifteen (15) calendar days after the end of the period for which the claim is being made. Forward this completed Mileage Reimbursement Claim Form to: Swissport, 2150 Smithtown Ave, Ste 4, Ronkonkoma, NY 11779.

I certify that I provided transportation for the above named child on the dates indicated.

Signature of Parent/Guardian	Date		Phone Number	Printed Name of Parent/Guardian	Social Security # of Parent/Guardian
FOR SWISSPORT USE ONLY		×	X	X 2= \$	
	One-Way Mileage	# of Days	Reimbursement Rate		

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	FORMAT - "invoice n	o. or claim no." description										
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	FORMAT - "invoice n	o. or claim no." description										
LINE#	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	G	RANT	GRTDETAL		G/LACCOUNT	SUBSIDIARY	AMOUNT
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	FORMAT - "invoice n	o. or claim no." description										
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4										
NVOICE NO or CI	CLAIM NO and DESCRIPTION									
	FORMAT - "invoice no. o	r claim no." description								
NC Depart	rtment					Amount Appro	ved \$			
Contact P	Person					Date				
Telephone	e No					Comptrollers A	pproval			

NASSAU COUNTY REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

		NUMBER	AND		1111	CAI	ION				
3	□ New Vendor OR	Change of Existing ☐ Name Change ☐ Address Change	[it Apply) ☐ Add/Ch ☐ Add/Ch	_				ion 🗆		t Change R Change
Section 1	I – Vendor Inforn	nation (*requi	ired)								
1. Federal	ID No or Social Sec	urity No.									
2.Vendor	Name:										
3.Vendor	Remittance Address	:									
4. Vendor	Contact Person:										
5. Vendor	Contact Telephone	No.:									
	E-Mail Address:										
A. The vendo Federal II	answer the questions or/payee ID number provided D# [] Social Security # [payee incorporated: No []	above is: C. Is a m. Yes D. Is ven.	edical or lega s[] No[] dor/payee an s[] No[]					Educ		r Pre-Sch gram	arly nool Special
Section II	-Financial Institutio	on Information-	Complete tl	is section	only if	you wo	uld like	to be pa	id elec	ronica	lly.
8b. Routi	ng Transit Number: ated at the bottom of your check) ng Transit Number ced (if applicable):										
9b. Bank	Account Number: Account Number Be ced (if applicable):	ing									
10. Accou	ınt Name:										
	Name: (8a.)										
111241111	(8b.)										
12. Please	include a VOIDED	check or Bank I	etter for	verifica	tion.						
Check her	re [] if you wish to	be removed fro	n electroi	ic payn	nents a	nd wo	uld lik	e to re	ceive p	aper c	hecks.
number (or I am (b) I have not be (c) the IRS has a Certification In of under reporting provision of this I understand that I further understand	or Certification: Cert in waiting for a number to be issue een notified by the Internal Reve notified me that I am no longer is instructions-You must cross out ing interest or dividends on you it is document other than the certified tif I have completed Section II it and that in the event that an erro annot be implemented, Nassau C	ed to me), and (2) I am no mue Service (IRS) that I a subject to backup withhole item (2) above if you hav ax return. For real estate cation required to avoid b that I authorize payments oneous electronic paymen	ot subject to ba im subject to be ding. (3) The ir e been notified transactions, it ackup withhold to be received t is sent, Nassa	kup withho ckup withho formation p by the IRS t em (2) does ing. by electronia County res	lding beca- olding as a rovided on hat you are not apply. c funds tra- serves the r	use: (a) I a result of a this form currently The IRS nsfer into the	m exempt failure to is correct subject to does not r the bank a erse the e	from back report all to the best backup we require you coount des lectronic p	cup withho interest or of my kn rithholding or consent signated in ayment, Is	olding or dividends owledge. g because to any	s or L
Authorize	ed Signature	Print Na	me/Title				Da	ite			
(NC Department Office use or	e] Form Submitted By tt) nly; disburse type 2 acco Comptroller's Office		(Cont	act #)				FORM	4700 S SO	Rayles d C	letohen 2010
rassau County	Comptroner's Office							FURM	+/UU-W9.	Kevisea U	ctober 2019