# **SWISSPORT**

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

# PARENT MILEAGE REIMBURSEMENT PROGRAM

Date:	Child's Name:
	Address:

## 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

<sup>\*\*</sup> 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)

· ·	<b>5</b> ,
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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FOR SERVICE PROVIDER USE ONLY			
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21 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	21 22 23 24 25 26 27 28 29 30
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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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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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.

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Signature of Parent/Guardian	Date		Phone Number	Printed Name of Parent/Guardian	Social Security # of Parent/Guardian
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	One-Way Mileage	# of Days	Reimbursement Rate		

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	FORMAT - "invoice n	o. or claim no." description										
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LINE#	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/LACCOUNT	SUBSIDIARY	AMOUNT
	r CLAIM NO and DESCRIPTIO	N (50):								
		or claim no." description						_		
LINE#	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/LACCOUNT	SUBSIDIARY	AMOUNT
4										
INVOICE NO or	r CLAIM NO and DESCRIPTIO									
	FLYTINAL - "INVOICE NO.	or claim no." description								
NC Dep	artment					Amount Appro	ved \$			
Telepho	one No.					Comptrollers A	pproval			

# NASSAU COUNTY REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

	NUMBERAN	DCERTI	TOATI	011		
□ New Vendor OR	Change of Existing (Check A  □ Name Change □ Address Change	☐ Add/Change	e Electronic Remit e Check Remittan	ttance Information ace Information	_	t Change R Change
Section I – Vendor Inform	nation (*required)					
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.:					
6. Vendor E-Mail Address:						
7. Please answer the questions A. The vendor/payee ID number provided Federal ID# [ ] Social Security # [ B. Is vendor/payee incorporated: Yes [ ] No [ ]	above is: C. Is a medical or Yes [ ] N	Io[ ] ee an employee of N		Interve Educati	of Child in Eantion or Pre-Sch ion Program ] No[ ]	
Section II -Financial Institution	on Information-Compl	ete this section on	ly if you would	d like to be paid	l electronica	lly.
8a. Routing Transit Number:  (Located at the bottom of your check)  8b. Routing Transit Number:  Replaced (if applicable):	Being					
9a. Bank Account Number: 9b. Bank Account Number Be Replaced (if applicable):	ing					
10. Account Name:						
11.Bank Name: (8a.)						
(8b.)						
12. Please include a VOIDED	check or Bank Letter	for verification	n.			
Check here [ ] if you wish to	be removed from elec	tronic paymen	its and woul	d like to rece	ive paper o	checks.
14. Vendor Certification: Cert number (or I am waiting for a number to be issue (b) I have not been notified by the Internal Revee (c) the IRS has notified me that I am no longer is Certification Instructions-You must cross out of under reporting interest or dividends on you to provision of this document other than the certification I understand that if I have completed Section II of I further understand that in the event that an error that a reversal cannot be implemented, Nassau Completed.	ed to me), and (2) I am not subject mue Service (IRS) that I am subject subject to backup withholding. (3) item (2) above if you have been no ax return. For real estate transactication required to avoid backup with that I authorize payments to be reconeous electronic payment is sent,	t to backup withholding to to backup withholdin The information provid- ptified by the IRS that yons, item (2) does not a ithholding. reived by electronic fun Nassau County reserve	g because: (a) I am of g as a result of a far- ded on this form is of you are currently su- apply. The IRS doordids transfer into the sist the right to revers	exempt from backup illure to report all int correct to the best of abject to backup with es not require your of bank account design se the electronic pay	o withholding or terest or dividends f my knowledge. sholding because consent to any nated in Section I ment, In the even	s or
Authorized Signature	Print Name/T	itle		Date		
[Dept. Use] Form Submitted By (NC Department) Office use only; disburse type 2 acco Nassau County Comptroller's Office		(Contact #)		FORM#7	00-W9 Revised C	October 2010