

Month Year November 2024

*Daily Pick up and/or Drop Off Source Record for Medicaid Reimbursement or Private Pay*

PRINTED NAME PROVIDING SERVICE: \_\_\_\_\_

SIGNATURE OF PERSON PROVIDING SERVICE: \_\_\_\_\_

**By signing this form I acknowledge that I have provided transportation to and or from Paladin Day Services.**

Supervisor review Signature: \_\_\_\_\_

**MUST BE SIGNED BY SUPERVISOR PRIOR TO GIVING TO ACCOUNTING**

☐ Medicaid Reimbursement

Date Turned in to ACCOUNTING: \_\_\_\_\_ (Within 3 days of end of mo

☐ Private Pay Record

RIDER NAME: \_\_\_\_\_ RIDER NUMBER \_\_\_\_\_

F	Sa	S	M	T	W	Th	F	Sa	S	M	T	W	Th	F	Sa	S	M	T	W	Th	F	Sa	S	M	T	W	Th	F	Sa		TOTAL
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		

USE ADDITIONAL SHEETS IF MORE THAN FIVE CONSUMERS TRANSPORTED

1																														
2																														

Check ☒ TRIPS PROVIDED 0 EQUALS NO TRANSPORTATION

**Remember one copy goes to Kasey to enter and then it will be given to Accounts Payable**

**ACCOUNTING USE ONLY** PAID ON: \_\_\_\_\_ CHECK # \_\_\_\_\_ \$5/trip

**YOU MUST BE SURE THAT ACCOUNTING HAS A COPY OF THE TRANSPORTATION AGREEMENT ON FILE. IF NOT, YOU WILL NOT BE PAID FOR TRANSPORTATION UNTIL WE DO. THIS IS FOR PARENTS/CAREGIVERS.**