ND RYAN WHITE PROGRAM PART B REQUEST FOR TRANSPORTATION REIMBURSEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISEASE CONTROL AND FORENSIC PATHOLOGY
SFN 58584 (7-2023)

Client's Name	RW Number	RW Agency

Procedure:

- Transportation must be for accessing HIV-related medical care and HIV-related services within North Dakota.
- Return this completed form to your case manager. Provider's signature is optional.
- Mileage reimbursement amount will be based on the current state rate for use of a private vehicle.

City of Residence	Date(s) of Travel
City of Destination	Miles Traveled
Bus Fare/Monthly Bus Pass Amount ($)	Mileage Reimbursement Amount ($)

Explanation of Travel

Provider's Name (please print)	Telephone Number

Signatures

Provider (optional)	Date
Client/Guardian	Date
Case Manager	Date