CPS- Foster Care Provider Mileage Reimbursement Form

The rates on this form are valid beginning October 1, 2026. **Before completing this form: Mileage must be approved in advance by the CPS caseworker and supervisor unless there is an emergency.** Complete Section C for medical transportation and Section D for non-medical transportation. Submit this form with the CPS-522 Request for Payment Invoice. Enter each applicable service code as a separate line on the CPS-522, including the total amount for each service code. If necessary, use a second form to document all trips.

A. Provider

NAME	RESOURCE #
ADDRESS (street/PO box, city, state, zip)	MONTH/YEAR

B. Client

NAME	CLIENT ID #

C. Medical (approved by CPS, after Medicaid NEMT denial)- **Service Code 09-007**

Date *Example: 10/1*	**Total Miles** *Example: 448 miles*	**Trip Details** (from/to, purpose, etc.) Example: *Pierre to Sioux Falls roundtrip – specialty dental care*	**Unit Price**	**Amount** (miles X $0.76)	**Other CPS Children Transported (C#)**
			$0.76/ mile		
			$0.76/ mile		
			$0.76/ mile		
			TOTAL AMOUNT		

D. Non-medical (approved ahead of time by CPS)- **Service Code 09-008**

Date *Example: 10/1*	**Total Miles** *Example: 448 miles*	**Trip Details** (from/ to, purpose, etc.) Example: *Pierre to Sioux Falls roundtrip – family time visit*	**Unit Price**	**Amount** (miles X $0.76)	**Other CPS Children Transported (C#)**
			$0.76/ mile		
			$0.76/ mile		
			$0.76/ mile		
			$0.76/ mile		
			$0.76/ mile		
			TOTAL AMOUNT		

I certify that the mileage reported above is accurate, was incurred for the purposes listed, was approved in advance or incurred due to an emergency, and has not been reimbursed by another source.

Provider Signature _____ Date _____