HPC Transportation Mileage Log

Month/Year:		**Provider Name:**		***Number of persons transported is 1 unless otherwise noted.**
Provider Contract #		**License Plate #**		

Date	Name of Person	Medicaid #	Travel Description			Modified Vehicle Rate (Y/N)	Odometer Reading		Total Miles	Group Size*
			Origination	Destination	Reason		Start	Finish		

Provider Signature: _____ **Date:** _____

HPC Transportation Mileage Log

DAILY CHECKLIST (check response)		SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	DATE OF SERVICE:							
Permanent Fasteners to secure wheelchair to floor or side of the vehicle		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Safety Harnesses or Seat Belts		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Stable Access Ramp or Hydraulic Lift		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Date problems were fixed:								
I verify that the above equipment is in working condition to safely transport passengers who utilize a wheelchair. Any equipment not meeting this standard will be immediately repaired before use.	Driver's Initials:							

Date	Notes	Initials