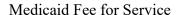




## Family and Friends Mileage Reimbursement Program New Driver Enrollment Sheet

Full Name of Member:	Date:
Medicaid ID Number :	
Home Address:	Date of Birth:
Vehicle and Driver Information being us	ed for Mileage Reimbursement Program:
Driver License Number and State:	
Expiration Date:	
License Plate Number / State of Primary	Vehicle:
Please list the Driver Name (First, Middl	e, Last)(Printed):
Date of Birth:	<u> </u>
Additional / Alternative Vehicle and Driv Reimbursement Program:	er Information being used for Mileage
<b>License Plate Number / State of Primary</b>	Vehicle:
Please list the Driver Name (First, Middl	e, Last):
Date of Birth:	<u> </u>
I, the member, hereby understand and ag	gree that: (initial next to each)
participation in the Family and Friends	Program is both voluntary and a privilege and that
failure to comply with any of the rules of the	ne program may result in my immediate termination from
this mileage reimbursement program	
Medicaid fraud is a serious crime and f	raudulent submissions for reimbursement under this
program can result in criminal penalties up	to 7 years in State prison







if I move I must update and provide proof of my new address to [Medicaid] before I submit my
next reimbursement form
driver must have a valid driver's license in order to receive reimbursement under this program
driving without a license, driving with a suspended license, or driving while designated as a
habitual offender are all crimes in New Hampshire and submissions made under this program can
and will be used against me in criminal proceedings
if the New Hampshire Department of Health and Human Service or its partners has reason to
suspect any potential violations of the Family and Friends Program I understand that my driver's
history, motor vehicle records, and/or my criminal background may be checked
having a criminal history or driving record does not necessarily prevent me from participating in
this program
my participation in this program will be governed in accordance with the Department of Health
and Human Services Administrative Rule He-W 574

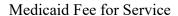
## **Documentation Required to be Included in this Application**

Please send the completed form, along with a copy of the license for each driver listed in the form, by text photo, fax, or email to CTS:

Coordinated Transportation Solutions, Inc, 35 Nutmeg Drive, Suite 120, Trumbull, CT 06611,

Or a scanned or legible photograph from smartphone should be emailed to <u>FF@ctstransit.com</u> or Faxed to (203) 375-0516.







Please complete additiona	l forms if you need	d to register m	ore drivers.
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<b>Applicant Signature and date:</b>	

The above signed hereby agrees to all initialed statements above and swears that all information contained in this application and the information in the accompanying documents is true and accurate and that any material falsities contained herein may result in a prosecution for false swearing under RSA 641:3