



Home Services Program Travel Agreement

Individual Provider Name: _____

Santrax ID: _____

From Customer		To Customer		Distance	Travel (minutes)	Trips per Week	Time per Week
Name (Last, First)	Case #	Name (Last, First)	Case #				
Total Travel (minutes) per Week:							

Individual Provider Certification

I understand that I may only claim travel time when I travel between Home Services Program customers whom I serve on the same work day.

I understand that I may not claim travel time for the commute from my home to a customer's home or from a customer's home to my home.

I understand that I must subtract any time spent on personal business (e.g., lunch, breaks, errands, etc.) from travel time.

I understand that I must complete a Home Services Program Travel Time Sheet every time I travel and submit it to my Illinois Department of Human Services (DHS) Division of Rehabilitation Services (DRS) office along with my regular Home Services Program Time Sheet in order to be paid for travel time.

I agree to notify my Illinois Department of Human Services (DHS) Division of Rehabilitation Services (DRS) office within 10 calendar days if any of the information I have provided here changes, and understand that I may be required to complete a new Travel Agreement with the new information.

I certify that the above information is true to the best of my knowledge. I understand that falsification of any information submitted on this form could lead to criminal prosecution.

Individual Provider Signature: _____

Date: _____