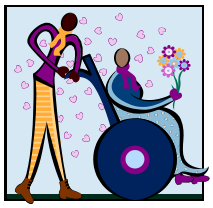

Public Transportation Reimbursement

Guidelines

- You must be a San Mateo County Independent Provider who is currently working to be eligible for this benefit.
- You will be reimbursed up to **$50.00** for a monthly transportation pass or cash value added to your Clipper Card.
- Reimbursement is on a first-come, first-served basis and shall be limited to 125 individuals each month.
- You can apply for only one reimbursement per month.
- Claims for monthly passes will be processed for the month of the pass.
- Claims for cash value purchased between the 1st and the 15th of any month will apply to reimbursement for that month. Claims for cash value purchased between the 16th and the last day of the month will apply to reimbursement for the next month. For example, cash value purchased on November 14 will be applied to November, whereas cash value added on November 17 will be applied to December.
- Provided you follow the guidelines mentioned above, a reimbursement check will be mailed to you.

Instructions

1. Purchase a Clipper Card (Go to www.Clippercard.com). The $3.00 charge to purchase a Clipper Card will be reimbursed for the first 125 providers who request it on their claim form.

2. Purchase a monthly bus pass or add cash value to your Clipper Card. Save your receipt.

3. Complete a "Request for Public Transportation Reimbursement" claim form. Indicate if you are requesting reimbursement for a monthly pass, cash value or the purchase of a Clipper Card. Attach the original Clipper Card receipt to the claim form. Forms are available through the Public Authority (650) 573-2047 or SEIU Local 521.

4. Please submit your claim form as soon as possible. Claim forms must be received within 30-days of the date shown on the receipt. Any claim received after the 30-days will not be processed.

5. Submit the claim form to:

   Public Authority
   P.O. Box 5892
   San Mateo, CA 94402

Keep copies of your claim form and receipt for your records.

IHSS PUBLIC AUTHORITY
Request for Public Transportation Reimbursement

Provider's Name: ________________________________ Provider ID: ____________________
(Print **full** name clearly) (Can be found on Timesheet)

Address: ____
(City) (State) (Zip Code)

Phone #: __________________________________

Amount loaded on Clipper Card $________________ **(original receipt must be attached)**

For: ☐ Monthly Pass ☐ Cash Value ☐ Purchase of Clipper Card

- -

(For Office Use Only)

PUBLIC AUTHORITY ACTION

☐ Provider eligibility checked through CMIPS ________
Initials

☐ Approved for ________________ Amount: $_______________
Month/Year

☐ Disapproved (Reason: ____)

______________________________ ______________________________
Signature of Supervisor Date

File #: ____________________ Logged: _____________________

Keep copies of your claim form and receipt for your records.