

## Welfare to Work Mileage Claim Form

Please mail directly to: \_\_\_\_\_  
 Employment & Benefit Services Division  
 P.O. Box 1320  
 Santa Cruz CA 95061

ETS/EW Worker #: \_\_\_\_\_

Participant Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Month covered by this claim: \_\_\_\_\_ Miles per month authorized on NOA: \_\_\_\_\_

Date	Origin and Destination	Purpose or Approved WTW Activity	Odometer		Miles Claimed
			End	Start	
Adjustment miles for a transportation advance or transportation overpayment					
Total miles claimed after adjustments for advances					

**Total miles** \_\_\_\_\_ **X 56 cents per mile** (IRS rate as of 1/1/14) = \$ \_\_\_\_\_

*I certify that the information entered on this form is true and correct and that the activities specified on this form were approved in advance by my ETS/EW, and were necessary for CalWORKs Welfare to Work participation.*

Signature of Welfare to Work Participant \_\_\_\_\_ Date \_\_\_\_\_

Sr. ETS Approval (required if over \$500):

\_\_\_\_\_  
Signature / Date

Date sent/faxed to Fiscal: \_\_\_\_\_ ETS/EW certification: \_\_\_\_\_