**TRANSPORTATION REIMBURSEMENT REQUEST**

**FOR PERSONS TREATED UNDER A MENTAL HEALTH COMMITMENT**

(Del. Code: Title 16, Chapter 51, Section 5122 (e) as amended 6/06)

Please submit form at time of service to:

DSAMH - Contracts Unit
1901 N. DuPont Hwy., Springer Bldg.
New Castle, Delaware 19720

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**Complaint No:** ________________________________

**Name of Dept/Troop#** ________________________________

**Time (00:00)**

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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</thead>
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**Date (MM/DD/YYYY) and Time (00:00)**

**Name of Transporting Officer:** ________________________________

**IBM#** ________________________________

**Name of Second Officer:** ________________________________

**IBM#** ________________________________

**Client Transported:**

<table>
<thead>
<tr>
<th>From /Origin</th>
<th>ODOMETER Start</th>
<th>To/Destination</th>
<th>ODOMETER End</th>
<th>Trip Travel Miles</th>
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**Total Trip Travel Miles:** ________________________________ @ $0.31 each

= $ ________________________________

*Plus Custody Fee ($100)*

= $ ________________________________

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**TOTAL REIMBURSEMENT REQUESTED:** = $ ________________________________

I hereby certify that the information on this Reimbursement Form is complete and accurate to the best of my knowledge, and that the above-mentioned client has been transported to the designated receiving facility in accordance with the Delaware Code.

**Name of Officer Completing this Form:** ________________________________

Print full name

**Signature**

**Date and Time**

**Title/Unit**

**Telephone**

DSAMH 2013-03