

**SOUTH CENTRAL CHILD DEVELOPMENT INC.
Travel Expense Statement**

Staff Gov. Board Policy Council

Name: _____ Program: Head Start

Address: _____

Destination: _____ Purpose of Travel: _____

Departure Date and **Time**: _____ Return Date and **Time**: _____

Private vehicle odometer readings only:

Beginning reading _____ **Ending reading** _____
Total Miles _____ @ \$ _____ per mile..... \$ _____

Child Care: Head Start Parents

Child Care Time:	# of Children	1	2	3	4
Beginning time: _____	Rate per hour	\$3.00	\$6.00	\$9.00	\$12.00
Ending time: _____	Maximum	\$24.00	\$48.00	\$72.00	\$96.00

(Date and Check which meals are being claimed for each date)

Date	Meals	Breakfast	Lunch	Dinner	Lodging	Total	FOR OFFICE USE ONLY

	In State	Out-of-State
Meals		Meals
Breakfast (Leave before 5:31am)	\$6.00	\$10.00
Lunch (Leave before 11:31am)	\$11.00	\$14.00
Dinner (Leave before 5:31 pm) or (Return after 7:59 pm)	\$15.00 / \$32.00	\$21.00 / \$45.00

Total Expenses Claimed \$ _____
Total Advance Amount Received by Traveler \$ _____
Total Amount Due to Traveler or SCCD (circle one) \$ _____

 I certify that this statement, the amounts and attachments are true, correct and complete to the best of my knowledge and belief.

Signature of Traveler: _____ Date: 11/15/2018

Approved by: _____ Date: 11/15/2018