EXPENSE CLAIM FORM

NAME: **LICENSE PLATE:**

ADDRESS:

CITY: **STATE:** **ZIP CODE:**

BOARD/COMMISSION: **PHONE:**

California Association of Local Behavioral Health Boards and Commissions

DESTINATION: **PURPOSE:** **MONTH/YEAR:**

Date:								
Time:								
Location To:								
Location Fr:								

	TRANSPORTATION COSTS	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
(68321)	Airplane Fare								$0.00
(68326)	Railroad Fare								$0.00
(68327)	Ground Transportation (Taxi, Shuttle, etc.)								$0.00
(68323)	Private Auto Mileage (**Enter Miles)								$0.00
(68388 & 68389)	Rental Vehicle								$0.00
(68328)	Other (Tolls, Parking, etc.)								$0.00

	TRAVEL RELATED EXPENSES								
(68317)	Breakfast -- $16								$0.00
(68317)	Lunch -- $17								$0.00
(68317)	Dinner -- $31								$0.00
(68329)	Incidentals $5 with receipts								$0.00
(68315)	Hotel/Motel Room & Tax								$0.00

EXPENSES - OTHER - *Please list.*

								$0.00
								$0.00
								$0.00
							TOTAL	**$0.00**

*** Mileage Rate (2024):0.67*

Least expensive means of transportation will be reimbursed.

Refer to Expense Reimbursement Policy.

Accounting Classification: _____

CLAIMANT CERTIFICATION

I hereby certify that the above is a true statement of the travel or business expenses incurred by me; I have not and will not receive reimbursements for them from other entities.

SIGNATURE: _____