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:								Receipts Y / N
Time:								
Location To:								
Location Fr:								

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

TRAVEL RELATED EXPENSES									
(68317)	Breakfast -- $7								
(68317)	Lunch -- $11								
(68317)	Dinner -- $23								
(68329)	Incidentals $5 with receipts								
(68315)	Hotel/Motel Room & Tax								

EXPENSES - OTHER - *Please list.*									

*** Mileage Rate (2020):0.575 (Often car rental is lower.)*

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:_____