

CONSULTANT EXPENSE REPORT

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Type of Service _____ Date of Service _____

Points of Travel _____

Departure Date _____ Time _____ Return Date _____ Time _____

Odometer Readings:

Beginning _____ Ending _____ Number of Miles @ \$.42 _____

CHILD CARE RATES – WHEN APPLICABLE FOR HEAD START PARENTS

Child Care Time: # of Children	1	2	3	4	5
Beginning: _____ Rate/Hour	3.00	6.00	9.00	12.00	15.00
Ending _____ Maximum	24.00	48.00	72.00	96.00	120.00

Expenditures:

Fee _____

Per Diem _____

Mileage _____

Child Care _____

Air Fare _____

Total Expenses _____

Check Made Payable to:

Consultant _____

Other _____

Plane ticket receipts and motel receipts must be attached.

Signature _____ Date _____

Approved by: T/TA Coordinator _____

Executive Director _____