

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

Name _____ **Program** _____ **Head Start** _____
Address _____
 Mode of Transportation _____
 Purpose of Travel _____
 Destination(s) _____
 Departure Date and Time _____
 Return Date and Time _____

Transportation:

\$ _____

Private vehicle odometer readings only:
Beginning reading _____ **Ending reading** _____
Total Miles _____ @ \$.42 per mile..... \$ _____

Child Care: Head Start Parents NA
 (See other side)

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

Date	Meals:	Breakfast	Lunch	Dinner	Lodging	Total	FOR OFFICE USE ONLY

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 _____
 Approved by _____ Date _____

Travel Allowance Policy information printed on reverse side

South Central Child Development, Inc.
401 Walnut Street SW
Wagner SD 57380

- I. **Meals** will not be reimbursed for routine travel within the program's service area, which is part of a days work. **Exceptions:**
- a. Approved overnight travel.
 - b. Luncheon or dinner meetings, which are part of a scheduled business meeting. (Example: P.C., Board, HSAC, H.S. Association)
 - c. One day travel outside of the service area involving a distance of 100 miles or more from the employee's duty station.
 - d. One day travel within the service area which is all part of a day's work and would require the employee to return home after 7:59 p.m. (dinner only).
 - e. Approved Policy Council or subcommittee travel, which would require travel of 100 miles or more from the member's home.
- II. **Overnight** travel will be kept at a minimum and will generally be limited to travel requirements outside of the service area of the program for: **All overnight travel must have advanced approval by the Director.**
- a. Administrative functions for the program.
 - b. Training workshops.
 - c. Attendance of Head Start Association meetings.
 - d. Travel of 100 miles or more from duty station to attend a meeting beginning before 9:00 a.m. or which will last for 2 or more days in duration.
- III. **Mileage** will be paid for approved travel when an agency vehicle has not been assigned or is not available. **Use of a personal vehicle must be approved by the Director.**
- IV. All lodging must be submitted with a travel follow-up before payment will be made. Reimbursement rates will be paid at a rate approved by the Governing Board. Mileage reimbursements must be supported by odometer readings.
- V. Travel advances must be approved by the Director for agency travel involving:
- a. Out-of-Area travel
 - b. Overnight travel

Allowable Reimbursement Rates when authorized

		In State	Out-of-State	
I.	Meals		1. Meals	
	Breakfast (Leave before 5:31am)	\$6.00		\$10.00
	Lunch (Leave before 11:31am)	\$11.00		\$14.00
	Dinner (Leave before	\$15.00		\$21.00
	(Return after 7:59 pm)	\$32.00		\$45.00
II.	Lodging (receipts required) \$55.00 + tax (9-1/6-1) or \$70.00 + tax (6-1/9-1)			
III.	Mileage for approved travel.			
	Private owned auto - \$.42/mile			
	Private owned auto when agency vehicles is available - \$.23/mile			
	Special Needs Passenger/Cargo Van - \$.43/mile			

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

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