ROSEBUD COUNTY
Taxable Meals Reimbursement

NAME: _____

ADDRESS: _____

CITY, STATE: _____

PURPOSE OF TRAVEL: _____
*TAXABLE MEALS occur when there is NO overnight stay.
*No Claim needs to be attached to this form.

Date of Travel	Point of Departure	Destination	Time Departed	Time Return

(EXCLUDING THOSE INCLUED IN REGISTRION FEES)

Reimbursement fee schedule:

Meals		IN State	OUT of State	*With Receipt
Breakfast	12:01a - 10:00a	$ 5.00	$ 7.00	$7.00
Lunch	10:01a - 3:00p	$ 6.00	$ 11.00	$11.00
Dinner	3:01p - 12:00a	$ 12.00	$ 18.00	$23.00
Total		$ 23.00	$ 36.00	$41.00

Coding/Accounting

Fund	Dept	Funct.	Act.	Sub.	Obj.	$$

DATE: _____ TOTAL AMOUNT: _____

SIGNATURE: _____

APPROVED BY: _____

COMMISSIONER APPROVAL: _____/_____

*Meals with a receipt will be paid face value of receipt up to the federal rate.

Please turn Taxable Meals Reimbursement form into the Commissioners office no later than the 20th of each month to ensure payment that pay period