ROSEBUD COUNTY

Must be attached to a CLAIM FORM

(Use this form if you have an overnight stay – Non-Taxable will be paid on separate check)

NAME: _____

ADDRESS: _____

PURPOSE OF TRAVEL: _____

Date of Travel	Point of Departure	Destination	Time Departed	Time Returned

LODGING: $_____

NOTE: Must stay overnight & have a hotel receipt attached. If not available and overnight stay is included, reimbursement for lodging will be $12.00 per night.

In-State Rate $ _____ plus bed tax. Out-of-State Rate $ _____ plus bed tax.

MEALS: $ _____

Reimbursement Fee Schedule – employee must be in travel status for more than 3 consecutive hours. One meal is permitted per travel shift. Two meals are permitted if travel exceeds "travel shift" time. A "travel shift" is that period 1 hour before or one hour after shift MCA 2-18-502

Meals	IN State		OUT of State		* With Receipt	
Breakfast 12:0la - 10:00a		$ 8.25		13.00		$13.00
Lunch 10:01a - 3:00p		$ 9.25		15.00		$ 15.00
Dinner 3:0lp - 12:00a		$ 16.00		26.00		$ 26.00
Total						

EXCLUDE MEALS INCLUDED IN REGISTRATION FEE. Meals with a receipt will be paid face value of receipt up to the federal rate excluding alcohol and tips. Please use hash marks to indicate which meals you are requesting reimbursement for.

TRANSPORTATION: $_____

Select only if eligible for reimbursement:

- ☐ Personal Vehicle Mileage (Roundtrip) _____ x mileage rate = _____
- ☐ City, County or State Vehicle
- ☐ Commercial Transportation Fare $_____
- ☐ Other (please explain) _____ $_____

OTHER EXPENSES: Please explain _____

All applicable receipts must be attached with claim. Per policy, claimant has up to 3 months after travel to request reimbursement or the claim could be denied.

DATE: _____ **TOTAL AMOUNT:** _____

Signature: _____ **Approved By:** _____