EARLY CHILDHOOD POLICY COUNCIL STIPEND REQUEST FORM

Instructions:
Please provide all information requested on this form and return. We will complete your STIPEND REQUEST with the information you provide. Once complete, please remember to sign and date the form.

Name: _____ Date: _____

Please provide an address where you would like to receive your stipend check:

Address: _____

City: _____ State: _____ Zip code: _____

Purpose or reason for stipend:

_____

SECTION I: Please complete the following fields if requesting SERVICE or WAGE REPLACEMENT stipend:

REQUEST TYPE	**AMOUNT REQUESTED**	**DESCRIPTION** (include time span and hourly rate)
Child Care		
Wage Replacement		
Substitute		
Other		

SECTION II: Please complete the following fields if requesting TRAVEL EXPENSE stipend:

Street Address Departed From: _____

City Departed From: _____ Date: _____ Time: _____ AM

Destination Address: _____

City Returned To: _____ Date: _____ Time: _____ AM

AIR TRAVEL: Did a CHHS employee book your flight? ☐ **YES** ☐ **NO** (if no, please skip to Driving section)

Method of transportation from home/business to airport and return:

☐ Personal Vehicle
License Plate Number: _____
Round Trip Mileage: _____ (reimbursed at $.575/mile)

☐ Airport Parking (reimbursed at $10/day)
Parking Cost : $ _____ (enclose receipt)

☐ Other: _____ $ _____ (enclose receipt)

Method of transportation from airport to meeting and return OR from airport to hotel to meeting and return:

☐ CHHS Staff ☐ Hotel Courtesy Shuttle ☐ Taxi $ _____ (enclose receipt)

☐ Rental Car (enclose receipt) ☐ Rideshare Company (enclose receipt) ☐ Other: _____

$ _____ (enclose receipt)

DRIVING: If you drove to this meeting, please complete this section.

☐ Personal Vehicle
License Plate Number: _____
Round Trip Mileage: _____ (reimbursed at $.575/mile)

☐ Parking
Parking Cost: $ _____ (enclose receipt)

☐ Rental Car (enclose receipt)

☐ Bridge Tolls $ _____ (enclose receipt)

☐ Company Vehicle/ Carpool

☐ Other: _____

$ _____ (enclose receipt)

LODGING: If you stayed in a Hotel, please complete this section.

☐ One Night ☐ Two Nights ☐ _____ Nights (enclose receipt; must show $0.00 balance due)

Please note: Up to $95.00/night (plus tax) will be reimbursed in most counties. A higher rate may be available, please see CHHS's travel Reimbursement Policy for further details.

PER DIEM: Please keep all receipts for meals and incidental expenses for your records. The state will reimburse only the actual cost, not to exceed the maximum allowance, for each meal and incidental expense.

	Day 1	Day 2	Day 3	Day 4
Cost of Breakfast (up to $7)	$	$	$	$
Cost of Lunch (up to $11)	$	$	$	$
Cost of Dinner (up to $23)	$	$	$	$
Cost of Incidentals (up to $5)	$	$	$	$

Please note: You will not be reimbursed for breakfast if lodging includes a complimentary breakfast.

Please return completed form along with receipts, invoices, letters or documentation via email or post mail to:

Aruna Sridharan
California Health and Human Services
Agency 1600 9th Street, Rm 460
Sacramento, CA 95814
aruna.sridharan@chhs.ca.gov

I hereby certify that the above is a true statement of the expenses incurred by me in accordance with DPA regulations in the service of the State of California, and that all items shown were for the official business of the State of California.(1)

_____ _____

Date

(1) The reimbursement of travel expenses is governed by Government Code Sections 19815.4(d), 19816, and 19820. These sections allow the Department of Personnel Administration (DPA) to establish rules and regulations which define the amount, time, and place that expenses and allowances may be paid to representatives of the State while on State business.