



**CHILDREN'S DIVISION
TRAVEL EXPENSE LOG FOR CHILDREN IN FOSTER CARE**

FOR THE MONTH OF _____ Month, Year _____

RESOURCE PARENTS NAME _____ DVN _____ vendor type _____

ADDRESS: _____

CHILD'S NAME _____ DCN _____

TRAVEL EXPENSE			PURPOSE	# OF MILES ROUND TRIP	Total miles	
DATE OF TRAVEL	ADDRESS OF DESTINATION	X current rate			\$	

SIGNED _____ DATE _____
 (RESOURCE PARENT)

WORKER APPROVAL _____ DATE _____

SUPERVISOR APPROVAL _____ DATE _____

NOTE: If more than one child is taken to medical care or counseling on one trip, travel expense can be charged to only one child.
 For additional information regarding allowable mileage reference CWM Section 4 Chapter 11 Attachment C 11/08