

**Migrant Head Start  
POLICY COUNCIL/COMMITTEE REIMBURSEMENT CLAIM**

**Parent Information**

Name \_\_\_\_\_ Social Security No \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Mailing Address if different \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Agency \_\_\_\_\_

**Meeting Information**

Date: \_\_\_\_\_ Location: \_\_\_\_\_

Type:  Policy Committee  Policy Council  
 Sub Committee  Other \_\_\_\_\_  
 Representative \_\_\_\_\_  Alternate \_\_\_\_\_

**Meeting Expenses**

Miles claimed (roundtrip) \_\_\_\_\_

Childcare total hours \_\_\_\_\_

Number of children \_\_\_\_\_

Age of children \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Name of childcare provider: \_\_\_\_\_

Address: \_\_\_\_\_

Meals: Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_

<b><u>For Office Use Only</u></b>	
Mileage Total .....	\$ _____
_____ x _____ x \$ _____ = .... \$ _____	
(# children X # hours X \$Rate)	= Childcare Total
Meals Total: .....	\$ _____
Policy Council Stipend:.....	\$ _____

*I hereby testify that the information above is true and correct.*

Signature of Claimant \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only**

Date Approved: \_\_\_\_\_ **TOTAL AMOUNT \$** \_\_\_\_\_

Authorized By: \_\_\_\_\_  
Signature Title

ACCOUNT	LN	VENDOR	AMOUNT	DESCRIPTION
		V		
		V		
		V		

Warrant No. \_\_\_\_\_ Date Paid \_\_\_\_\_

Distribution: White & Yellow – Business Office Pink - Claimant