



# Interoffice Memo

DATE: December 14, 2017

PHONE: (909) 388-0820

FROM: **RAQUEL RAMOS**, Executive Secretary II  
Behavioral Health

A handwritten signature in black ink that reads "Raquel Ramos".

TO: **BEHAVIORAL HEALTH COMMISSIONERS**

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SUBJECT: **NEW TRAVEL REQUEST AND TRAVEL EXPENSE REPORT**

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Please allow this memo to serve as a notice of the new the new Travel Request and Travel Expense Report form that replaces the Employee Reimbursement Form. This is also a reminder on the previously existing parameters for submitting requests for reimbursement.

## **FREQUENCY OF SUBMISSIONS**

- Submit claims monthly when total claim amount is at or exceeds \$25.00.
- May submit multiple months on one claim until claim is at or exceeds \$25.00.
- May submit claims for less than \$25.00 when Fiscal Year (FY) deadline is approaching or mileage reimbursement rates are changing.

## **DEADLINES/CUT OFF DATES**

- Submit claims no later than six months from date of travel, even if claim is less than \$25.00.
  - Claims submitted later than six months from date of travel require a justification memo signed by the Department of Behavioral Health (DBH) Director.
- Exact FY cut off dates change from year to year. The deadline to submit claims to meet FY cut off dates is often the first week of May.
  - Submitting a claim after the FY cut off deadline often results in delay of receiving reimbursement by an additional 4-6 weeks.
  - Submitting a claim after the FY cut off deadline but within six months from date of travel is not recommended, however will be processed as normal.
- Mileage reimbursement rates often change with calendar year and/or fiscal year. Commissioners are notified as the form changes.

## **MINIMUM MILEAGE TO CLAIM**

- Per County Code Ordinance, Amended Ordinance 3849 (2001); (b) EXPENSES: (1) All Travel which is twenty (20) miles or less round trip from a member's home shall not be reimbursed. If the round trip exceeds twenty (20) miles, then all mileage is reimbursable as provided herein.
- Commissioners may claim mileage to Behavioral Health Commission meetings if they fall within minimum mileage requirements.

## **DRIVER REQUIREMENTS**

- Per County of San Bernardino Policy Manual; COUNTY BOARDS, COMMISSIONS AND COMMITTEES, No. 02-09; L. Indemnification and Insurance Coverage: 4. In an appointee is authorized

to drive a personal vehicle on County business, proof of a valid California Driver's License and the state minimum required vehicle liability insurance shall be submitted to the appropriate County Department.

**ATTACHMENTS**

- DBH Fiscal recommends attaching a map with directions/miles for each of the miles claimed.
- DBH Fiscal recommends attaching a flyer for an event for any expenses that are being claimed.

**COMPLETION OF FORMS**

Please see the attached Travel Request and Travel Expense Report. This will be provided to all Behavioral Health Commissioners during orientation with the DBH Director.

**CURRENT FORMS**

The current ERF may be requested via email or phone by contacting Raquel Ramos at [rramos@dbh.sbcounty.gov](mailto:rramos@dbh.sbcounty.gov) or (909) 388-0820. Hard copies of the form are also available at each Behavioral Health Commission Executive Session.

RR

Attachment(s): Travel Request and Travel Expense Report



COUNTY OF SAN BERNARDINO
TRAVEL REQUEST AND TRAVEL EXPENSE REPORT

(Attach any items that support this request along with a justification memo if out-of-state or out-of-country)

Trip Request Trip Expense Report Day Trip Expense Report No Request Expense Report

Only for Travel After October 1, 2017

Employee Name: First Name Last Name
From Date: First date of travel
End Date: Last Date of Travel
Reason: Behavioral Health Commission related (meeting, training, field work, etc.)
DBH Program Behavioral Health Commission
DBH Cost Center DIRMHC
SAP Trip #\*
DBH Fiscal Staff #:

EMPLOYEE ID:
Occup. Unit
Location: Travel destination
State: Ca
Activity Type: (choose) Meeting, Training, Field work
Assigned Hdqtrs: Same as primary residence. (City)
Primary Residence: City you live in (City)

Table with 10 columns: Date, TRAVEL EXPENSE TYPE #, Vendor or Description, CC or TC, Last Five Digits CalCard (CC) or Temp. Card (TC), DBH Cost Center, SAP Cost Assignment Code #, \$ Amount, Select: Estimate Actual, Meals Per Diem

Table with 8 columns: Date, TRAVEL EXPENSE TYPE, Vendor or Description, DBH Cost Center, SAP Cost (Fiscal Use) Assignment Code, \$ Amount, Select: Estimate Actual, Meals Per Diem

Total \$ -
Total County Credit Card Expenses \$ -
Total Employee Reimbursements \$ -
Total Private Mileage (from page 2) \$ -
GRAND TOTAL \$ -

\*Shaded fields are for Fiscal Use Only

- Travel Expenses Types and Descriptions
AIR Airfare (Paid by Employee)
AIRC Airfare (Paid by County)
BAGC Baggage (Paid by County)
BAGG Baggage (Paid by Employee)
BKFC Breakfast (Paid by County)
BKFT Breakfast (Paid by Employee)
CONC Conference (Paid by County)
CONF Conference (Paid by Employee)
DINC Dinner (Paid by County)
DINN Dinner (Paid by Employee)
FUEC Fuel (Paid by County)
FUEL Fuel (Paid by Employee)
LNCC Lunch (Paid by County)
LNCH Lunch (Paid by Employee)
LODC Lodging (Paid by County)
LODG Lodging (Paid by Employee)
MEAD Meal Adj for High Cost (Paid by Employee)
MEAL Group/Training Meal (Paid by Employee)
MEDC Meal Adj High Cost (Paid by County)
MELC Group/Training Meal (Paid by County)
OTHC Other Travel Exp (Paid by County)
OTHR Other Travel Expenses (Paid by Employee)
PARC Parking (Paid by County)
PARK Parking (Paid by Employee)
RCAC Rental Car (Paid by County)
RCAR Rental Car (Paid by Employee)
TAXC Taxi (Paid by County)
TAXI Taxi (Paid by Employee)
TOLC Toll Fees (Paid by County)
TOLL Toll Fees (Paid by Employee)

Sign: SIGNATURE Traveler Date
Supervisor Date
Phone: Mail Code: Click here to select authorized signer Approving Authority Date

The undersigned declares under penalty of perjury that the expenses hereon claimed were necessary in attending to County Business in conformity with the policies established by the Board of Supervisors, and that no part thereof has been previously paid. In claiming reimbursement, I hereby certify that I have a valid California Driver's License and that I carry vehicle liability insurance as required by the County

Employee Name: First Name Last Name

Employee ID: \_\_\_\_\_

MILEAGE RECORD FOR TRAVEL IN PRIVATELY OWNED VEHICLE

Date	Travel Time From	Travel Time To	Governmental Purpose	PRIVATE MILEAGE			\$ Amount
				Start Location	End Location	NO. OF MILES (round to miles)	
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				Total Miles \$		0.535	\$ -