

# TEXAS COUNCIL OF CHILD WELFARE BOARDS

## REQUEST FOR REIMBURSEMENT

MEETING NAME \_\_\_\_\_ DATE \_\_\_\_\_

Name \_\_\_\_\_ Telephone No. \_\_\_\_\_

Mailing Address \_\_\_\_\_  
P.O. Box or Street \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

### Breakdown of Expenses:

1. Driving From: \_\_\_\_\_ To: \_\_\_\_\_

(Shared a ride with \_\_\_\_\_)

Miles \_\_\_\_\_ x \$0.725 (72.5 cents) \$ \_\_\_\_\_

2. Air Fare \$ \_\_\_\_\_

3. Meals (Original receipts, no tips or alcoholic beverages) (not to exceed \$59/day)

Date	Breakfast	Lunch	Dinner	Total

Total reimbursement for meals \$ \_\_\_\_\_

4. Lodging (Original Hotel Receipts not to exceed hotel's meeting rate) \$ \_\_\_\_\_

(Shared room with \_\_\_\_\_)

5. Other expenses (taxi, shuttles, tolls, parking) \$ \_\_\_\_\_

Total Requested Reimbursement: \$ \_\_\_\_\_

Updated January 2026

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ORIGINAL RECEIPTS FOR ALL CLAIMED EXPENSES MUST ACCOMPANY THE REQUEST FOR REIMBURSEMENT AND MUST BE RECEIVED BY MS. GIBSON ONE (1) WEEK FROM MEETING DATE. IF FORMS ARE NOT RECEIVED WITHIN 7 DAYS OF MEETING DATE, REIMBURSEMENT WILL BE DENIED EXCEPT WITH APPROVAL OF EXECUTIVE COMMITTEE**

**SEND THIS FORM AND ORIGINAL RECEIPTS TO:**

**TEXAS COUNCIL OF CHILD WELFARE BOARDS**  
Shmeka Gibson, Executive Director  
PO Box 42636 Austin, TX 78704  
901 592-8978 sgibson@tccwb.org