ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Out-of-State Travel Approval Request

AGENCY NAME	GRANT NAME	TRAVEL STATUS (DATES & TIMES)	
		BEGIN DATE:	END DATE:
		BEGIN TIME:	END TIME:
EMPLOYEE NAME(S):			
PURPOSE OF TRAVEL AND LOCATION			

ESTIMATED COSTS			
	Amount		Amount
Air Fare		Meals with Overnight Stay	
Car Rental		Meals without Overnight Stay	
Lodging		Other Miscellaneous Travel (List Items)	
Other (list items):		Conference, Education, & Training Registration	
Subtotal Costs	$ 0.00	**Subtotal Costs**	$ 0.00
Estimated Total Costs	$ 0.00		

Authorized Contractor's Name _____ Signature _____ Date _____

FOR AHCCCS USE ONLY:

Agency Head or Approved Delegate _____ Signature _____ Date _____

EXCEPTIONS TO STATE POLICY (SUCH AS LODGING RATES IN EXCESS OF STATE RATES, ETC.) REQUIRES THE APPROVAL OF AHCCCS. IN SUCH CASES, THIS FORM, WITH AN EXCEPTION MEMO ATTACHED, IS TO BE FORWARDED TO AHCCCS. THE FORM AND MEMO WILL BE RETURNED TO THE AGENCY WITH AHCCCS' DETERMINATION.