

FUEL, TOLL & FERRY REIMBURSABLE EXPENSES CLAIM FORM EMD-036

(See WAC 118-04-360 for detailed instructions)

Washington Military Department
Emergency Management Division

CLAIMANT'S INSTRUCTIONS:

1. This form is in two (2) parts: **Part One** is required general information and eligible reimbursable fuel, ferry crossing, and toll bridge expenses. **Part Two** is to be completed by the local Director of Emergency management.
2. All responses **must be in ink** and all requested items **must be completed**. **DO NOT PRINT TWO-SIDED**
3. Claimant **must be a registered Emergency Worker or eligible organization** in accordance with Revised Code of Washington (RCW) 38.52, and Washington Administrative Code (WAC) 118-04, and must have been working under Emergency Management authority at the time the expense was incurred.
4. A state **Mission or Evidence Search Mission number** must have been assigned.
5. **Receipts** for all claimed expenses **must be included**. Fasten receipts smaller than 8.5x11 inches to letter size paper.
6. For fuel reimbursement, start mission with full tank and refuel as needed but not later than 24 hours following return from mission.
7. When completed, **this form must be signed on page two** by the claimant or claimant's representative.
8. **Claimant must be registered as a Payee (Vendor)** with the Department of Enterprise Services, Statewide Payee Desk (see: <http://www.des.wa.gov/services/ContractingPurchasing/Business/VendorPay/Pages/default.aspx>). **Enter Statewide Vendor Number (SVN) below.**
9. If claimant is unable to present and file the claim (due to incapacitation, etc.) or if claimant is a minor, or a nonresident of the state, the claim may be presented and filed on behalf of the claimant by claimant's legal representative, any relative, attorney, or agency representing the claimant.
10. **Submit original claim and all supporting documentation to your local Director of Emergency Management or Search and Rescue Coordinator (WAC 118-04-360).**

PART ONE:

To Be Completed By Emergency Worker (Claimant) or Representative

NAME OF CLAIMANT: _____ Last, First M.I. or Organization Name	EMERGENCYWORKER CARD NUMBER (if individual): _____
CLAIMANT'S ADDRESS: _____ City State Zip	COUNTY WHERE REGISTERED: _____ HOME PHONE: () _____ WORK PHONE: () _____
STATEWIDE VENDOR/PAYEE NUMBER (SVN): _____	Email: _____
DESCRIPTION OF VEHICLE: _____ Make Type (Car, PU, 4x4, Van) Year License # State	
COUNTY WHERE MISSION OCCURED: _____	MISSION OR INCIDENT # _____ DATE OF INCIDENT: _____
DATE & TIME DEPARTED HOME: _____	DATE & TIME RETURNED HOME: _____
WAS MISSION PARTICIPATION OVER 24 HOURS? YES ___ NO ___	WAS VEHICLE DRIVEN MORE THAN 100 MILES? YES ___ NO ___

TOTAL AMOUNT OF CLAIM: \$ _____

FUEL – Start Mission With Full Tank

TOTAL GALLONS PURCHASED:		(All Receipts Must Be Included)	TOTAL COSTS: \$
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BRIDGE/FERRY

(Multiple crossings on a mission for a vehicle must be added together)	(All receipts must be included)	TOTAL COSTS: \$
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LIST ALL PASSENGERS BELOW:

NAME	EMER. WORKER #	NAME	EMER. WORKER #

(If more space is needed, please attach additional sheets)

Attach Receipts To This Form and Submit To Your Local DEM Office for Processing. Emergency Worker (Claimant) or Legal Representative MUST Sign This Claim Form

I hereby certify or "declare" under penalty of perjury under the laws of the State of Washington that the foregoing is a true and correct claim for necessary expenses incurred by me or claimant and that no payment has been received by me or claimant on account thereof.

SIGNATURE OF EMERGENCY WORKER OR ORGANIZATION REPRESENTATIVE (CLAIMANT)	DATE	ADDRESS
		CITY STATE

If the Claimant is incapacitated from verifying, presenting, and filing the claim or if the claimant is a minor, or is a nonresident of the state, the claim may be verified, presented, and filed on behalf of the claimant by any relative, attorney, or agent representing the claimant. All claims for damages against the state arising out of tortuous conduct shall be presented to and filed with the Risk Management Office.

(Note: For general statutory provisions governing claims against the State of Washington, see chapter 4.92.100 RCW. For specific information regarding Emergency Management Worker Claims, see chapter 38.52 RCW)

PART TWO
To Be Completed By The Emergency Management/Services Director For The Jurisdiction Where The Claimant Is Registered or For The Jurisdiction Where The Incident Occurred.

I have reviewed the information in Part One and it is true to my best knowledge and belief.

DIRECTOR'S SIGNATURE	DATE
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Don't Forget To Check:

- [] Copy of EMD-078 with Emergency Worker name showing?
- [] Receipts as specified included?
- [] Form(s) properly filled out and signed?

If total claim for mission/incident number exceeds \$2,000.00, before sending in the claim, a compensation board must review the claim in accordance with RCW 38.52.210. Contact Washington Emergency Management Division for further information.

Mail completed form with all documentation to:

**STATE SAR COORDINATOR
 EMERGENCY MANAGEMENT DIVISION
 WASHINGTON MILITARY DEPARTMENT
 CAMP MURRAY WA 98430-5122**