

**EXTRAORDINARY EXPENSE CLAIM FORM EMD-089**

**(See WAC 118-04-380 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 extraordinary 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. If claimant is an emergency worker, claimant must be registered 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. If claimant is a local government organization, extraordinary expense claims may be submitted if the expenses meet the following criteria:
  - a. Are in **DIRECT SUPPORT OF VOLUNTEERS** working under a state EMD mission number.
  - b. **Represent extraordinary**, expendable obligations such as for feeding or lodging for volunteers participating in missions for more than 24 hours.
5. A state **Mission number or Evidence Search Mission number** **MUST** have been assigned. Mission number *must* have been in force for more than 24 hours.
6. **Receipts for all claimed expenses must be included.** Fasten receipts smaller than 8.5x11 inches to letter size paper.
7. Reimbursed for feeding and lodging expenses will not exceed rates in current State Travel Regulations. Documentation for feeding expenditures must include type meal (breakfast, lunch, dinner) and number of emergency workers served at each meal.
8. When completed, this form must be signed by claimant or claimant's representative.
9. **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.**
10. 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.
11. **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 CLAIMANT OR REPRESENTATIVE**

NAME OF CLAIMANT: \_\_\_\_\_  
LAST, FIRST, M.I. OR ORGANIZATION

EMERGENCY WORKER CARD NUMBER: \_\_\_\_\_

CLAIMANT'S ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

COUNTY WHERE REGISTERED: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

STATEWIDE VENDOR/PAYEE NUMBER (SVN): \_\_\_\_\_

EMAIL: \_\_\_\_\_

MISSION OR INCIDENT # \_\_\_\_\_ DATE OF INCIDENT: \_\_\_\_\_

COUNTY WHERE MISSION OCCURRED: \_\_\_\_\_

DATE & TIME DEPARTED HOME: \_\_\_\_\_

DATE & TIME RETURNED HOME: \_\_\_\_\_

**TOTAL AMOUNT CLAIMED: \$** \_\_\_\_\_

**EXPENDITURE DETAILS:**

FEEDING EXPENDITURES \* Total Amount: \$ \_\_\_\_\_

LODGING EXPENDITURES\* Total Amount: \$ \_\_\_\_\_

TRANSPORTATION EXPENDITURES Total Amount: \$ \_\_\_\_\_

(For fuel reimbursement use Form EMD-036)

OTHER MISCELLANEOUS EXPENDITURES:  
(List below) (if more space is needed, please attach additional sheets)

1. \_\_\_\_\_ \$ \_\_\_\_\_

2. \_\_\_\_\_ \$ \_\_\_\_\_

3. \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL OTHER MISCELLANEOUS EXPENDITURES \$ \_\_\_\_\_**

(\* Reimbursed will not exceed rates in current State Travel Regulations. Documentation for feeding expenditures must include type meal (breakfast, lunch dinner) and number of emergency workers served at each meal.)

**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 (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 RCW 38.52 and chapter 8, Laws of 1971, 1st Extraordinary Session, Section 4)

**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

**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 be established 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**