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 i**s 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

EMERGENCY WORKER CARD NUMBER (if individual): _____

COUNTY WHERE REGISTERED: _____

CLAIMANT'S ADDRESS: _____

HOME PHONE: (___)_____

_____
City State Zip

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:_____

MISSION PARTICIPATION OVER 24 HOURS?_____

VEHICLE DRIVEN MORE THAN 100 MILES?_____

TOTAL AMOUNT OF CLAIM: $_____

FUEL – Start Mission With Full Tank

TOTAL GALLONS PURCHASED: _____ COSTS: $ _____
(Multiple fuel purchases on a mission for an individual must be added together) (All receipts must be included)

BRIDGE/FERRY

BRIDGE OR
FERRY: _____ COSTS: $ _____
(Multiple crossings on a mission for a vehicle must be added together) (All receipts must be included)

LIST ALL PASSENGERS BELOW:

PASSENGER NAME: _____	EMER. WORKER CARD #: _____	PASSENGER NAME: _____	EMER. WORKER CARD #: _____
PASSENGER NAME: _____	EMER. WORKER CARD #: _____	PASSENGER NAME: _____	EMER. WORKER CARD #: _____
PASSENGER NAME: _____	EMER. WORKER CARD #: _____	PASSENGER NAME: _____	EMER. WORKER CARD #: _____
PASSENGER NAME: _____	EMER. WORKER CARD #: _____	PASSENGER NAME: _____	EMER. WORKER CARD #: _____

(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 County 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

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

Form EMD-036 (Rev. 09/12) All other versions are obsolete and should not be used.