

**EXTRAORDINARY EXPENSE CLAIM FORM EMD-089**

**Washington Military Department  
Emergency Management Division**

**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.
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 on behalf of the volunteers, if the expenses meet the following criteria:
  - a. Are in DIRECT support of volunteers working under a state DEM mission number.
  - b. Represent extraordinary, expendable obligations such as for feeding or lodging volunteers.
5. A state Mission/Incident number or Evidence Search Training Mission number must have been assigned.
6. Receipts for all claimed expenses must be included.
7. Mission number must have been in force for more than 24 hours.
8. When completed, this form must be signed by claimant or claimant's representative.
9. Claimant's social security or tax ID number must be included with claim.
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. If total claim exceeds \$2,000.00, before sending in the claim, a compensation board must be established in accordance with RCW 38.52.210. Contact the State Emergency Management Division for further information.

**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.

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

CLAIMANT'S ADDRESS: \_\_\_\_\_  
City State Zip

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

HOME PHONE: ( ) \_\_\_\_\_

WORK PHONE: ( ) \_\_\_\_\_

SOCIAL SECURITY/ TAX ID NO. \_\_\_\_\_

COUNTY MISSION/INCIDENT TOOK PLACE: \_\_\_\_\_ MISSION OR INCIDENT # \_\_\_\_\_ DATE OF INCIDENT: \_\_\_\_\_

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

