



**NEW MEXICO CORRECTIVE ACTION FUND
REIMBURSEMENT CLAIM**

Please fill out this form and submit it, along with Cost Detail Forms, invoices and backup documentation, and a completed W-9 (if applicable) to:

**New Mexico Environment Department
Petroleum Storage Tank Bureau - Reimbursement Section
1301 Siler Road, Building B, Santa Fe, NM 87507**

Please submit two copies of every item. You must submit original signatures and notary seals on each affirmation.

- Check here if you have received a letter confirming your compliance determination.
- Check here if you have a current disclosure form.
- Check here if the Department has pre-approved the work described in this claim.

If you have not already requested a compliance determination, **please do so now. The Department cannot pay your claim until it has made a compliance determination.** The Department will reimburse only those costs that have been pre-approved by the Bureau Project Manager and conform to the current Department Fee schedule.

ATTACHMENT CHECKLIST

PLEASE ATTACH IN THE FOLLOWING ORDER

- Claim Form
- Signed and dated notarized Affirmation and Assent to Audit
- Applicable Cost Detail Forms
- Original invoices in the standard format
- Receipts for expenses (time & materials)
- Copies of cancelled checks (front & back) unless the claim is assigned to the invoicing party
- Disclosure Forms
- Copy of appropriate workplan letter and any Amendments. **Circle deliverable for which claim is being made.**
- W-9 if necessary

Name of Owner & Owner ID at time of release:	_____
Name of Operator & Operator ID at time of release:	_____
Name of Responsible Party at time of release:	_____

Part I: APPLICANT INFORMATION

Name: _____

Address: _____

E-mail: _____

Claim Contact Name: _____

Phone: _____

Social Security or Federal Tax ID#: _____

Part III: PAYEE

(Fill this out **ONLY** if you are assigning payment to someone)

Name: _____

Mailing Address: _____

Phone: _____

E-mail: _____

Federal Tax ID# of Payee: _____

Nature of Interest in Site: _____

Part II: FACILITY INFORMATION

Name of Site: _____

Address: _____

Site #: _____ Facility #: _____

Phase of Corrective Action being claimed: _____

<input type="checkbox"/> MSA	<input type="checkbox"/> Ph 3		Please check one:
<input type="checkbox"/> Ph 1	<input type="checkbox"/> Ph 4		<input type="checkbox"/> UST
<input type="checkbox"/> Ph 2	<input type="checkbox"/> Ph 5		<input type="checkbox"/> AST

The application for payment must be for cost of the completed deliverable.

Workplan Approval Date: _____ Amount: _____

Workplan ID #: _____ Claim Amount: _____

Deliverable ID(s): _____

Exact Name of Deliverable: _____

Estimated Date of Deliverable: _____

Invoice #: _____

INSURANCE INFORMATION

Do you have insurance for releases of regulated substances at this site (for this release)?

If YES, answer questions A through D. YES NO

A. What is the extent of coverage (i.e. maximum payments)? _____

B. Have you filed a claim for this release, and if so, in what amount? YES NO

AMOUNT: _____ CLAIM # _____

C. What amount has the insurance company paid to date? _____

D. Insurance Company Name: _____