STATEWIDE MUTUAL AID AGREEMENT (SMAA)
ASSISTING PARTY CLAIM NARRATIVE FORM

Assisting Party Organization: _____

Address/Zip Code: _____

_____

Business Phone: _____ **FAX #:** _____

E-Mail (Optional): _____ **Federal Employer ID# (EIN):** _____

Contact Person (Print/Type): _____ **Title:** _____

Assisting Party Jurisdiction: _____
(City or District in which County, County(s), Statewide)

Dates of Emergency Response: _____

Federal Declaration (Check Applicable): ____ **FSA** ____**DR** ____ **EM** **Number:** _____

Types of Assisting Party Employees: _____

SMAA Requesting Party: _____
(State/County/City/District/Other)

How Requested?
___ **State EOC Mission #(s)** _____
_____
___ **Local Dispatch** _____
___ **Other** _____

Type of Emergency Work:
___ **Debris Removal**
___ **Traffic Control**
___ **Evacuation Support**
___ **Security/Patrols**
___ **Emergency Response Calls**
___ **Search & Rescue**
___ **Firefighting/Firefighting Support**
___ **Emergency Shelters (Feeding and/or Lodging)**
___ **Animal Control/Sheltering**
___ **Other:** _____

Location of Emergency Work (County): _____

Other Emergency Work Comment as necessary: _____
_____
_____

Total Amount of Claim: $_____ Signature/Date: _____

Note: Separate Claim must be made for Debris Removal. Attach Expense Summaries as applicable.