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:(Cit	ty or District in which County, County(s), Statewide)
Dates of Emergency Response:	
Federal Declaration (Check Applicable	e): FSADR EM
Types of Assisting Party Employees: _	
SMAA Requesting Party:	(State/County/City/District/Other)
How Requested? State EOC	Mission #(s)
Local Dispa Other	atch
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 r	necessary:
Total Amount of Claim: \$	Signature/Date:
Note: Separate Claim must be made for D	ebris Removal. Attach Expense Summaries as applicable.