

DRY CLEANING FACILITY RELEASE TRUST FUND REIMBURSEMENT FORM

KDHE RF#
OFFICE USE ONLY

The Applicant must have applied and been determined eligible for the Drycleaning Facility Release Trust Fund (DFRTF) before requesting payment for corrective action expenses. All corrective action procedures must be pre-approved by KDHE prior to commencement of work and before any payment can be considered. Reimbursement will be based upon the DFRTF contractor procedures and unit costs current when the corrective action activities were performed.

- CHECK HERE IF COSTS WERE INCURRED PRIOR TO JULY 1, 1995
 CHECK HERE IF COSTS WERE INCURRED AFTER JULY 1, 1995

INSTRUCTIONS

1. All blanks MUST be completed.
2. If an item does not apply, write "N/A" in the blank.
3. Reimbursable costs must be substantiated by contractor or subcontractor invoices or other reasonable reliable documentation with sufficient detail to confirm that the costs were associated with site remediation.
4. If available, cancelled check(s) should be provided as proof of payment for eligible remedial activities; front and back copies should be included. If unavailable, an "Affidavit of Expenditures" must be provided for proof of payment for eligible remediation. Please also include sufficient supporting documentation with the affidavit.
5. An extra copy of this form and all supporting documentation (excluding reports) must be submitted.
6. A copy of all pre-approved work plans, reports, and KDHE approval documents for site corrective action activities must be submitted.
7. Please print neatly or type.
8. Sign and date the form on page 2.
9. Please review the KDHE regulations (K.A.R. 28-68-7) for a complete listing of requirements for the reimbursement of corrective action costs.

SECTION 1 OWNER, APPLICANT AND SITE INFORMATION

A. KDHE SITE CODE (if applicable): _____
APPLICANT'S SOCIAL SECURITY NO. (SSN) , or
FEDERAL EMPLOYERS I.D. NO. (FEIN): _____

B. APPLICANT NAME: _____ TELEPHONE NO. (_____)
(Name of person or business to appear on the reimbursement check)

CONTACT PERSON: _____

C. MAILING ADDRESS: _____
(Address to which check will be sent) (City) (State) (Zip)

D. FACILITY NAME: _____ COUNTY: _____

E. FACILITY ADDRESS: _____
(Street Address, NOT mailing address) (City) (State) (Zip)

SECTION 2 CONTRACTOR OR CONSULTANT INFORMATION

A. PROVIDE THE NAME AND ADDRESS OF THE COMPANY WHO PERFORMED THE INVESTIGATION AND CORRECTIVE ACTION WORK:

NAME: _____ CONTACT PERSON: _____

ADDRESS: _____
(Street or P.O. Box) (City) (State) (Zip)

SECTION 3 CORRECTIVE ACTION AND PAYMENT INFORMATION

A. DATE INVESTIGATION WAS INITIATED: _____

B. DATE CORRECTIVE ACTION WAS INITIATED: _____

C. TOTAL AMOUNT OF MONEY REQUESTED: \$ _____

AMOUNT INCURRED BEFORE JULY 1, 1995: \$ _____

AMOUNT INCURRED AFTER JULY 1, 1995: \$ _____

CONTINUED ON PAGE 2

TO EXPEDITE THE PAYMENT PROCESS, PROVIDE THE FOLLOWING INFORMATION.

Additional information may be attached to the Payment Request Form to provide clarification.

INSTRUCTIONS:

- (1) INVOICE DATE: Provide the date of all invoices. List separately and in chronological order.
- (2) INVOICE NUMBER: Provide the number of the invoice if available.
- (3) AMOUNT REQUESTED: Provide the amount requested from this invoice.
- (4) CANCELLED CHECK NUMBER: Provide the number of your cancelled check. If all checks are not available, please provide a completed Affidavit of Expenditure.
- (5) OTHER: If an Affidavit of Expenditure or other reasonable reliable documentation is provided, please place a check mark in this column next to the applicable item.
- (6) TOTAL AMOUNT: The total listed should equal the total requested in Section 3, line C, on the front page.

(1) INVOICE DATE	(2) INVOICE NUMBER	(3) AMOUNT REQUESTED	(4) CHECK NO.	(5) OTHER	OFFICE USE ONLY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

(6) TOTAL AMOUNT REQUESTED \$ _____

I certify that the payment requested reflects actual corrective action conducted at the site shown on the front page of this form. The applicant shall not knowingly make any false material statement or representation in any record, report, or other document filled, maintained or used for the purpose of compliance with the department. A person who does not uphold this requirement or other requirements as stated in the Drycleaning Environmental Response Act K.S.A. 65-34, 144, may incur, in a civil action, a civil penalty for every violation.

(Print or Type Applicant's Name)

(Applicant's or Contract Person's Signature) (Date)

Mail this form and supporting documents to:
KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
Bureau of Environmental Remediation
Assessment and Restoration Section
Curtis Building, 1000 SW Jackson, Suite 410
Topeka, KS 66612-1367

NEED ASSISTANCE?
CALL (785) 296-6370

CHECK LIST:

- _____ ALL BLANKS COMPLETED
- _____ PRINTED NEATLY OR TYPED
- _____ SUFFICIENT DETAIL PROVIDED TO DOCUMENT COSTS USED FOR KDHE APPROVED SITE REMEDIATION
- _____ FRONT & BACK COPIES OF CANCELLED CHECKS OR AFFIDAVIT OF EXPENDITURES PROVIDED
- _____ TWO COPIES OF SUPPORTING DOCUMENTS (excluding reports)
- _____ FORM IS SIGNED BY APPLICANT

INCOMPLETE REQUESTS WILL BE RETURNED