



THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF REVENUE

UNDERGROUND STORAGE TANK PROGRAM

100 Cambridge Street, 7th Floor - P.O. Box 9563
Boston, Massachusetts 02114-9563 ~ (617) 626-2600 ~ 617-626-2619(fax)



APPENDIX 4 – APPLICATION FOR REIMBURSEMENT

INSTRUCTIONS:

This form is to be used for reimbursement for Response Actions taken after July 1, 1994. Please type or print in black ink all items and sign the certification in Section VI. The total reimbursement claimed must be detailed on Appendix 4A - Listing of Costs, Expenses and Obligations, and supporting documentation must be attached. For tasks not listed in Appendix 3, the Reimbursement Fee Schedule, competitive bids must be obtained as detailed in Appendix 5, Competitive Bidding. Multiple Claims may be filed for a single Response Action according to the provisions of 503 CMR 2.00. All reimbursements from the Fund are subject to appropriation.

YOU MUST HAVE AN ELIGIBLE UST RELEASE NUMBER IN ORDER TO APPLY FOR REIMBURSEMENT.

Note: If you are not the UST System Owner, you must attach authorization to file this application as detailed in 503 CMR 2.08(3).

I. CLAIMANT INFORMATION	II. FACILITY INFORMATION
Name of Claimant <hr/> Contact Person <hr/> Mailing Address <hr/> City State Zip <hr/> Phone Number (include Area Code) <hr/>	Name of Dispensing Facility <hr/> Site Address <hr/> City State Zip <hr/> Contact Person <hr/> Dispensing Facility Phone Number (Include Area Code) <hr/>
IIIa. CONSULTANT INFORMATION : Provide the following information for the LSP of Record and/or the Primary Consultant for this Claim Name of Consulting Firm: <hr/> Mailing Address <hr/> City State Zip <hr/> Phone Number (include Area Code) <hr/> LSP Name <hr/> LSP License No. <hr/>	IIIb. CLAIM PREPARER INFORMATION Provide the following information for the Claim Preparer for this Claim: (If same as Consultant in Section IIIa, indicate "Same") Name of Firm: <hr/> Mailing Address <hr/> City State Zip <hr/> Phone Number (include Area Code) <hr/> Contact Name: <hr/> Contact email: <hr/>

IV. CLAIM SUMMARY

1. Eligible UST Release Number (mandatory): _____
2. Submittal Number: _____
3. Period covered by this submittal: From _____ to _____
4. Claimant is the (check one): Owner Owner and Operator Operator (attach authorization) Other (identify) _____
5. Please provide **ONLY** the last four digits of your Federal Employer I.D. Number (FEIN) or Social Security Number (SSN) : ____ _

V. Grand Total Reimbursement Claimed (from last page of Appendix 4A): _____

APPENDIX 4 – APPLICATION FOR REIMBURSEMENT, continued

Eligible UST Release Number: _____

Submittal Number: _____

VI. CERTIFICATION

I certify under the penalty of perjury that to the best of my knowledge and belief the statements made and information given herein are true as of the date hereof. I further certify that this submission is in compliance with M.G.L. c. 21J and 503 CMR 2.00. I hereby consent to all audits of payment and necessary inspections made to verify the accuracy of any submission to the Board and made pursuant to law and incidental to the issuance of licenses, registrations, permits, certificates and the operation of an UST System. I am aware that there are significant penalties for submitting false information, including possible fines, civil penalties and imprisonment. I further certify that I am authorized to execute this form. I agree to return any erroneous payment to the Board via the Department of Revenue within 10 days of either the receipt of the erroneous payment or the receipt of written notice from the Board or the Department of Revenue that an erroneous payment was made. I also understand and agree that all payments will be subject to intercept pursuant to G.L. c. 7A, s. 3 and 815 CMR 9.00.

Claimant's Signature: _____ **Date:** _____

Print Name: _____ **Title:** _____

I authorize the Board and the Department of Revenue to disclose and discuss with the Consultant and Claim Preparer identified in Section III any and all information associated with this Application for Reimbursement. This authorization shall remain in full force and effect until such time that a written notice of revocation is received by the Department of Revenue.

Claimant's Signature: _____ **Date:** _____

NOTE: Attach Appendix 4A - Listing of Costs, Expenses and Obligations