Department of Corrections
WASHINGTON STATE

LODGING AND TRANSPORTATION ASSISTANCE PROGRAM APPLICATION FOR REIMBURSEMENT

Visitors who live over 150 miles from where their loved one is housed may submit this request for lodging and transportation assistance. Approved participants may receive up to two $50 reimbursements towards the cost of hotel and/or gas associated with visits. This program is funded through the Incarcerated Individual Betterment Fund.

Individual name	DOC number	Facility	Date of visit

Which program are you applying for (Check box that applies)**:**

☐ **Lodging Assistance**	☐ **Transportation Assistance/Gas Reimbursement**
I will pay for hotel stay in full and will submit a copy of the paid hotel receipt for up to $50 reimbursement after my stay.	I request a reimbursement of up to $50 towards the cost of gas associated with this visit. I will submit a copy of a gas receipt(s) dated the day prior or after the day of visit.

VISITOR INFORMATION

Participant's information must be current in the Visitation Program.
To update your information, send email to dochqvisitunit@DOC1.WA.GOV.

Name (Last, First, MI)	Date of birth (mm/dd/yyyy) / /	Relationship as listed with Visitation	
Street address (Must match Visitation Program and valid ID card)	City	State	Zip
Email address	Distance (Residence to facility in miles)	Date visit scheduled / /	Contact phone number ( ) –

LODGING AND TRANSPORTATION INFORAMTION

Business name	Stay scheduled for / /	Confirmation number (required)
Business address		

YOU MUST AGREE TO THE FOLLOWING TO BE CONSIDERED FOR PARTICIPATION IN EITHER PROGRAM.	Agree
My name and address are current with the Visitation Program.	☐
My address is at least 150 miles away from the correctional facility I will be visiting.	☐
In the event I apply for and am approved for either Lodging Assistance and/or Transportation Assistance and visitation is cancelled when I arrive due to an emergency such as lockdown, I understand that the Department will pay the approved reimbursement as agreed upon.	☐
I understand that I will be denied future use of funding assistance if attempted abuse is determined (stays but does not visit the facility, attempts to use various visitor names to apply within a 30-day window, etc.).	☐
I understand that this application must be completed in full, submitted, and approved prior to my stay to qualify for reimbursement under either program.	☐
I understand that there are two opportunities for reimbursement per month, per incarcerated individual. More than two requests may result in a denial.	☐

LODGING AND TRANSPORTATION ASSISTANCE PROGRAM	
If I cancel my reservation or if I do not show for an existing reservation, I understand that I am fully responsible for any costs charged as agreed upon with the designated hotel when I made my reservation.	☐
I understand that my participation in this program is representative of families with incarcerated loved ones. As such, I will conduct myself in a manner that complies with the hotel/motel rules as to not compromise the relationship between the correctional facility, community hotel/motels, and families.	☐

Comments: _____

I understand that providing any inaccurate or misleading information and/or failure to agree to any of the terms above may result in the inability to participate in the program in the future.

_____ _____

Visitor's signature Date

(May sign electronically if submitting via personal email)

Submit the completed form and receipts to DOCHQLAP@DOC1.wa.gov

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Family Services Unit, Imaging file **COPY** - Accounting