Relocation Expense Reimbursement Program will compensate eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists recruited by the Los Angeles County Department of Mental Health (LACDMH) for relocation expenses.

Eligibility

To qualify for relocation assistance, individuals must be:

- Currently living more than 100 miles away from the location of their new work base.
- Moving to a new permanent residence (either rented or purchased) located within 50 miles of their new work base.
- Must be newly hired to the Department of Mental Health.

Amount Available

The maximum amount of Relocation Expense Reimbursement provided by LACDMH will be up to $15,000 per eligible employee. The payments will be made directly to the employee through Payroll and shall be treated as taxable wages subject to Federal and State payroll tax reporting and withholding obligations.

This amount can be reimbursed for eligible expenditure as set out below:

- Moving expense: actual costs for the packing, movement, and insuring of household goods from point of departure to point of arrival.
- Storage expense: if storage of goods is required at either point, up to 30 days of storage will be paid.
- Travel: costs for travel to and from the recruited site will be reimbursed for up to 3 round-trips for the employees, by means of the most cost-effective common transport carrier (e.g., airplane, bus, rental car) using coach fare.
- When using your personal vehicle, the County's standard mileage rate will apply. Travel expenses for commuting purposes are not eligible for reimbursement.
- Lodging & Temporary Accommodation: Lodging for eligible employee and dependents for a site visit to look for appropriate housing. The maximum site visit time frame permitted is 9 days total (3 days per visit). The time period for temporary accommodation is up to 12 weeks when a permanent move cannot be made immediately.
- All relocation expenses must be supported by valid receipts which include: credit card receipts or bank statements, the company's imprint, official letterhead, and the company's federal tax identification number when applicable (e.g., moving company invoices or quotes).
- The cost of engaging a relocation activity is deemed to be a reasonable expense for reimbursement, subject to the total costs claimed not exceeding the maximum allowance.

How to Claim

A complete claim form and copies of valid receipts should be submitted to Office of Administrative Operations at: MDIncentive@dmh.lacounty.gov. (Claims for relocation expenses must be made within 12 months of starting employment with the LACDMH.) For additional information and questions, please contact MDIncentive@dmh.lacounty.gov.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH
OFFICE OF ADMINISTRATIVE OPERATIONS
Relocation Expense Reimbursement for Mental Health Psychiatrists

Claim Form

Full Name: _____ **Social Security Number:** _____

E-Mail: _____ **Job Title:** ☐ **MHP** ☐ **SMHP** **Employee Number:** _____

Program Name: _____ **Unit Code:** _____ **Employment Start Date:** _____

Work Address: _____ **Phone:** _____

Home Address You Moved From: _____ **Date:** _____

Home Address You Moved To: _____ **Date:** _____

FINANCIAL ASSISTANCE	AMOUNT INCURRED	DATE(S) INCURRED	AMOUNT CLAIMED	RECEIPT ATTACHED*	APPROVED
Moving expenses	$		$	☐	☐
Storage expenses	$		$	☐	☐
Travel Expenses (Airplane, Rental Car, Mileage: $0.515/mile, etc.)	$		$	☐	☐
Lodging & Temporary accommodation expenses	$		$	☐	☐
Other (Please specify)	$		$	☐	☐
Sub-Total Amount	**$**		**$**		
Approved - Total Amount	**$**		**$**		
Comments:					

***All relocation expenses must be supported by valid receipts. Please attach the copies of the receipts.**

Declaration: I confirm that the above is correct and that the expenditure has been incurred. I request the Relocation Expense Reimbursement of $_____. I agree to repay Los Angeles County Department of Mental Health the full amount if I leave the organization within one (1) year.

Name of Claimant: _____ **Signature:** _____ **Date:** _____

Program Manager Name: _____ **Signature:** _____ **Date:** _____

TO BE COMPLETED BY OFFICE OF ADMINISTRATIVE OPERATIONS (OAO)

This claim is ☐ Approved ☐ Denied

Amount Approved for Payment $ _____

Comments: _____

_____

OAO Program Analyst/ Manager Signature: _____ **Date:** _____

TO BE COMPLETED BY HUMAN RESOURCES (HR)

Date Submitted to HR: _____ Employment Start Date: _____

Verified by HR Representative: _____ Date: _____

Net Amount: _____ Date Check Issued: _____