UNITED STATES AIR FORCE OUTSIDE THE
NATIONAL CAPITAL REGION
PUBLIC TRANSPORTATION BENEFIT PROGRAM APPLICATION

Purpose: Executive Order 13150 requires Federal agencies to establish transportation incentive program in order to reduce Federal employee's contribution to traffic congestion and air pollution and to expand their commuting alternatives. The purpose of the program is to encourage commuting by mass transportation and provide incentives to members/employee.

Applicant Information: Application must be filled out completely. Please print clearly as incomplete or illegible applications will not be processed.

Application (please circle one): Enrolling Making a Change Withdrawing

Name as it appears in payroll records or on paycheck:
Last Name: ______________________ First Name: _____________________ MI: ______ SSN (Last Four): _____________

City (Residence): __________________________ State: _______________ Zip Code: ________________

Air Force Installation/Activity: _________________
Duty Location (City): _______________________ Office Telephone Number (Commercial): (___)____________________

Are you (circle one):

Air Force Active Duty
Air Force Civilian Employee
Air Force NAF Employee
Air National Guard Active Duty
Air National Guard Civilian Employee
Air National Guard NAF Employee
Air Force Reserve Active Duty
Air Force Reserve Civilian Employee
Air Force Reserve NAF Employee

Name of the transportation system/company used. ____
What type of pass/ticket do you use? ____

B. Employee Certification:

WARNING: This certification concerns a matter with the jurisdiction of an agency of the United States and making a false, fictitious, or fraudulent certification may render the maker subject to criminal prosecution under Title 18, United States Code, Section 1001, Civil Penalty Action, providing for administrative recoveries of up to $10,000 per violation, and/or agency disciplinary actions up to and including dismissal.

I certify that I am eligible for a public transportation fare benefit, will use it for my daily commute to and from work, and will not transfer it to anyone else.
I certify that the monthly transit benefit I am receiving does not exceed my monthly commuting costs.
I certify that my usual monthly commuting costs are: $________
I certify that this information is accurate and agree to notify the installations POC of any change to employee status.
[Note: The current maximum benefit amount available to Air Force employees is $245.00 a month]. Please indicate your estimated transportation cost above.

Employee Signature: ____ Date: _______________

Supervisor Signature: ____ Date: ________________

C. Installation Point of Contact:

Name (Last, First):____ Signature:_________________________________

Unit Address:____ Phone: ___________________

PRIVACY ACT STATEMENT: This information is solicited under authority of Public Law 101-509. Furnishing the information on this form is voluntary, but failure to do so may result in disapproval of your request for the mass transportation fringe benefit. The purpose of this information is to facilitate timely processing of your request, to ensure your eligibility, and to prevent misuse of the funds involved. This information will be matched with lists at other Federal agencies to ensure that you are not listed as a carpool or vanpool participant or a holder of any other form of vehicle worksite parking permit with DoD or any other Federal agency. Partial social security number (SSN - last four numbers) will be used for record keeping purposes.

MASS TRANSPORTATION BENEFIT PROGRAM
DEPARTMENT OF THE AIR FORCE - OUTSIDE THE NATIONAL CAPITAL REGION
COMMUTER EXPENSES CALCULATION WORKSHEET

Calculate your MONTHLY MASS TRANSPORTATION EXPENSES based on the way (daily, weekly, monthly) that you pay for your commute. Round your expenses to the nearest dollar. Parking fees are not eligible for reimbursement and will not be included in your calculations.

Complete and sign this worksheet and submit it to your installation POC along with your MTBP application form. If your commuting costs change, you must complete a new worksheet and submit it to your POC, along with a new application form for "Making a Change".

APPLICANT NAME (Last, first, MI): **DATE:**

EMPLOYEE CERTIFICATION WARNING:

This certification concerns a matter within the jurisdiction of an agency of the United States and making a false, fictitious, or fraudulent certification may render the maker subject to criminal prosecution under Title 18, United States Code, Section 1001, Civil Penalty Action, providing for administrative recoveries of up to $10,000 per violation, and/or agency disciplinary actions up to and including dismissal.
I certify that I am employed by the above mentioned Federal Agency and am not named on a federally subsidized workplace parking permit with this or any other Federal agency, or that I will relinquish my permit before or upon receiving the fare benefit.
I certify that I am eligible for a public transportation fare benefit, will use it for my daily commute to and from work, and will not transfer it to anyone else.

SECTION I. COMMUTING COST CONVERTER

40 HOUR AND COMPRESSED WORKWEEK SCHEDULE CONVERTER

Please complete the conversion that applies to your work schedule commute.

a. 8 hour workday conversion	Daily Cost:$	21	Days Worked	Total:$________________
b. 9 hour workday conversion	Daily Cost:$	19	Days Worked	Total:$________________
c. 10 hour workday conversion	Daily Cost:$	17	Days Worked	Total:$________________
d. Other Work Schedule conversion	Daily Cost:$		Days Worked	Total:$________________
e. Weekly Work Schedule conversion	Weekly Cost:$______________	4	Wks per Month	Total:$________________

SECTION II. CALCULATING YOUR MASS TRANSPORTATION EXPENSES

Complete only those items that apply to your commute.

Parking fees are not eligible for reimbursement and will not be included in your calculations.

TRANSPORTATION TO WORK:

	COMPANY NAME	DAILY EXPENSE	WEEKLY EXPENSE	MONTHLY EXPENSE
BUS:		$	$	$
TRAIN:		$	$	$
VANPOOL:		$	$	$
OTHER:		$	$	$

TRANSPORTATION FROM WORK:

	COMPANY NAME	DAILY EXPENSE	WEEKLY EXPENSE	MONTHLY EXPENSE
BUS:		$	$	$
TRAIN:		$	$	$
VANPOOL:		$	$	$
OTHER:		$	$	$

TOTAL MONTHLY COST: $______________

I certify that the monthly transit benefit I am receiving does not exceed my monthly commuting costs.

APPLICANT SIGNATURE: POC SIGNATURE: