Memorandum of Understanding – Bargaining Unit 323: Article 8 ‘Hours, Meals, Call Rooms and Lounges’, Section 8 ‘Meals’

**The County will provide a meal stipend, not to exceed $27.00 per day, for resident physicians when on assignment outside of Los Angeles County facilities if meals are not provided by the host institution. Before approving the Meal Stipend Claim form, the respective facility GME office will verify that the resident seeking the stipend worked at a qualifying site as well as assure that resident submitted claim can be reconciled to their respective clinical/educational assignment and schedule. All schedules associated with the submitted claims must comply with ACGME duty hour requirements. Residents assigned to a non-hospital-based County site (i.e., Ambulatory clinic) without access to cafeteria services will be provided $15.00 per day for lunch. Eligible non hospital-based County sites are subject to approval of the resident’s respective GME office. Residents will have up to 30 business days to submit their Meal Stipend Claim form.**

**\*Note: As of 4/1/22 the 30 Business Day Deadline is temporarily suspended thru 5/31/23 to allow time for retroactive meal stipend claims to be submitted. The 30 Business Day Deadline will resume 6/1/23.**

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| **Employee Information** | | | |
| First Name: | Click or tap here to enter. | Last Name: | Click or tap here to enter. |
| Employee Number: | Enter Employee Number | Facility: | Choose an item. |
| Department: | Choose an item. | Program: | Choose an item. |
| Monthly Submissions: | Choose an item. | Year: | Choose an item. |

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| **Claim Information** | | | |
| **Date** | **Host Institution’s Name** | | **Claim** |
|  | **Hospital Based - $27 Max** | **Non-Hospital Based - $15 Max** |  |
| Select Date | Choose an item. | Choose an item. | $ Amount Claimed |
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| **Signature & Acknowledgement** | | | |
| I hereby request this reimbursement in accordance with provisions of my MOU and LA County Code. I acknowledge and attest to the accuracy of the information provided and certify that the above claimed stipend was for meals not provided to me when on assignment outside of Los Angeles County facilities and meals were not provided by the host institution. I am expected to retain receipts for submitted claims for two years from submission date. I understand this request requires review and approval from my local GME office. | | | |
| Signature |  | Date | Select Date |

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| **Approval by ACGME Program Director/Coordinator** | | | | | |
| I hereby verify that the resident seeking the stipend actually worked at a qualifying site as well as assure that resident submitted claims can be reconciled to their respective clinical/educational assignment and schedule. All schedules associated with the submitted claims must comply with ACGME duty hour requirements. | | | | | |
| Signature |  | | | Date | Select Date |
| Request Approved |  | | | | |
| Request Denied |  | Comment/Reason: | Click or tap here to enter text. | | |