

Claim for Damages Form Packet

Please *carefully read all of the information in this packet* before completing and submitting your Claim for Damages. Please note that no documents will be returned.

Presenting a Claim for Damages Form

RCW 4.96.020 requires citizens to present the Claim for Damages form to the Claims Agent of Kitsap Public Health District (KPHD). The law also requires KPHD to post on its website the Claim for Damages form with instructions.

Documents Contained in the Claim for Damages Form Packet

1. Instructions for completing the Claim for Damages Form
2. Claim for Damages Form
3. Medical Authorization
4. Vehicle Collision Form only for tort claims involving vehicle accidents/collisions
5. Mandatory Medicare Beneficiary Reporting Form

Legal Requirements for Presenting Claim for Damages Forms

In order to verify the claim and additional supporting information, the law requires that the Claim for Damages form be signed by:

- Claimant; or
- Person holding a written power of attorney from the Claimant; or
- Attorney in fact for the Claimant; or
- Attorney admitted to practice in Washington State on the Claimant's behalf; or
- A court-approved guardian or guardian ad litem on behalf of the Claimant

Submit the Claim for Damages Form and Supporting Documents in person or by mail to:

Claims Agent
Kitsap Public Health District
345 6th Street
Suite 300
Bremerton, WA 98337

Business Hours: Monday-Friday, 8:00 a.m. to 4:30 p.m.
Closed on weekends and official state holidays.

INSTRUCTIONS FOR COMPLETING A CLAIM FOR DAMAGES FORM

General Liability Claim Form

- ✓ Before filing a Claim for Damages Form, please read these instructions, the Claim for Damages form and other appropriate forms in their entirety.
- ✓ Type or print **clearly** in ink and sign the Claim for Damages form. **Do not staple or tape documents.** Do not put in claim form in binders or add divider tabs as all documents must be scanned.
- ✓ Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.
- ✓ If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

- ✓ The following are *examples* on how to complete the Claim for Damages Form:
 - 1) Smith, Karen Michelle – 02/20/1965
 - 2) #809234 (for use by Department of Corrections inmates only)
 - 3) 1234 College Way NW, Apt. 56, Seattle WA 98178
 - 4) PO Box 910, Seattle WA 98178
 - 5) Same (or residence at the time of incident)
 - 6) (206) 123-4567 – (206) 987-6543
 - 7) KMSmith@hotmail.com
 - 8) 8/9/2010 8:00 a.m.,
 - 9) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 8.
 - 10) Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22.
 - 11) I-5, Southbound, Milepost 109, near the Martin Way Exit
 - 12) Washington State Department of Transportation, Highway
 - 13) Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
 - 14) Unknown
 - 15) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 13 and 14. Also include a description of their knowledge. For example, if your sister was with you when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.
 - 16) Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
 - 17) If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.
 - 18) Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
 - 19) Please attach any additional documents that support your claim.
 - 20) Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of total compensation.

- ✓ If you are filing a personal injury claim, please sign and attach the Medical Release.
- ✓ If your claim involves a motor vehicle accident, please complete, sign, and attach the vehicle accident form.

11. If the incident occurred on a street or highway:

Name of street or highway	Milepost number	At the intersection with or nearest intersecting street
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12. State agency or department alleged responsible for damage/injury:

13. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

14. Names, addresses and telephone numbers of all state employees having knowledge about this incident:

15. Names, addresses and telephone numbers of all individuals not already identified in #13 and #14 above that have knowledge regarding the liability issues involved in this incident, or knowledge of the Claimant's resulting damages. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.

16. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

17. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom? Please attach a copy of the report or contact information.

18. Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

19. Please attach documents which support the allegations of the claim.

20. I claim damages from the Kitsap Public Health District in the sum of \$_____.

This Claim form must be signed by the Claimant, a person holding a written power of attorney from the Claimant, by the attorney in fact for the Claimant, by an attorney admitted to practice in Washington State on the Claimant's behalf, or by a court-approved guardian or guardian ad litem on behalf of the Claimant.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signature of Claimant

Date and place (residential address, city and county)

Or

Signature of Representative

Date and place (residential address, city and county)

Print Name of Representative

Bar Number (if applicable)

**Authorization for Release of Protected Health Information (PHI)
to
Kitsap Public Health District (KPHD)**

Name: _____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day _____ Year _____

I hereby authorize disclosure of my protected health information to the Kitsap Public Health District for purposes of processing my claim for damages filed with the Kitsap Public Health District.

I understand that by signing this document, I authorize the release of the following information:

Complete medical record for all services, including history and physical exam; progress notes; x-ray reports; inpatient admissions; operative notes; physical or other therapy; laboratory and other test reports; physician and physician assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record.

HIV Test Results and medical information related to HIV testing or treatment

Psychiatric, mental and behavioral health records, including treatment notes, assessments, testing documents and results, and medical records related to mental health diagnosis and treatment

Alcohol assessment, testing, referral or treatment records

All other chemical dependency assessment of treatment records

Pharmacy prescriptions and reports

All letters and memos received or sent, including electronic mail, referencing my treatment, compliance with treatment and any other subject related to my medical treatment

Information related to alleged sexual assault or sexually transmitted disease, including test results

Urgent care, outpatient or other clinic visit information

Gynecological and/or obstetrical information

All client records generated for or by governmental programs of which I am a client. Identify the program(s) and agency: _____.

Financial records related to my care and treatment

I understand the following: **(PLEASE READ AND INITIAL ALL STATEMENTS)**

_____ I understand that my records are protected under HIPAA/PHI regulations (federal law) and the
Initials Washington State Health Care Information Act (RCW 70.02).

_____ I understand that my health information may be subject to re-disclosure by the Kitsap Public Health District
Initials and not protected for purposes of evaluating and investigating the claim I have filed with the Kitsap Public Health District.

_____ I understand that the specific information to be disclosed in my medical record may include
Initials information regarding alcohol, drug or other controlled substance use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome.

_____ I understand that I may revoke this authorization at any time by notifying Kitsap Public Health District in
Initials writing, and that the revocation will be effective as of the date Kitsap Public Health District receives it. Any records obtained pursuant to this Authorization for Release of PHI prior to the revocation will be deemed authorized by me for release.

_____ I understand that this Authorization for Release will expire 90 days from the date I sign it. I can
Initials also authorize a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed by Kitsap Public Health District.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Kitsap Public Health District.

Signature of Authorizing Individual:

Date of Signature: _____

Telephone number: _____

Witness (where patient is over 13 and signing the release):

Where the signer is not the subject of the records:

I am authorized to sign this because I am the (attach proof of authority):

- Parent of minor
- Legal Guardian
- Personal Representative
- Other

To the Provider or Records Custodian:

Please send legible copies of all records to:

Claims Agent
Kitsap Public Health District
345 6th Street
Suite 300
Bremerton, WA 98337

MMSEA REPORTING COMPLIANCE DECLARATION

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a “conditional payment” so as not to inconvenience the beneficiary and recover after the insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers like the state of Washington), no-fault insurers, and workers’ compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly. Please answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been enrolled in Medicare Part A or Part B?												Yes <input type="checkbox"/>		No <input type="checkbox"/>							
<i>If yes, please complete the following. If no, proceed to Section II.</i>																					
Full Name: (Please print the name exactly as it appears on the SSN or Medicare card if available.)																					
[Grid for printing name]																					
Medicare Claim Number:												Date of Birth(Mo/Day/Year)									
Social Security Number: (If Medicare Claim Number is Unavailable)												-		-		Sex		Female <input type="checkbox"/>		Male <input type="checkbox"/>	

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print)	Claim Number
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Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form	Date
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If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print)	Claim Number
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For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form	Date
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VEHICLE COLLISION FORM

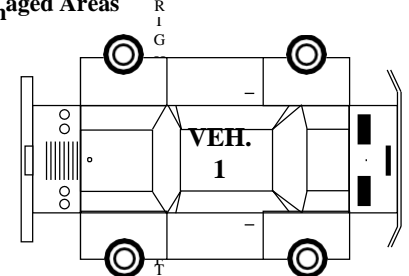
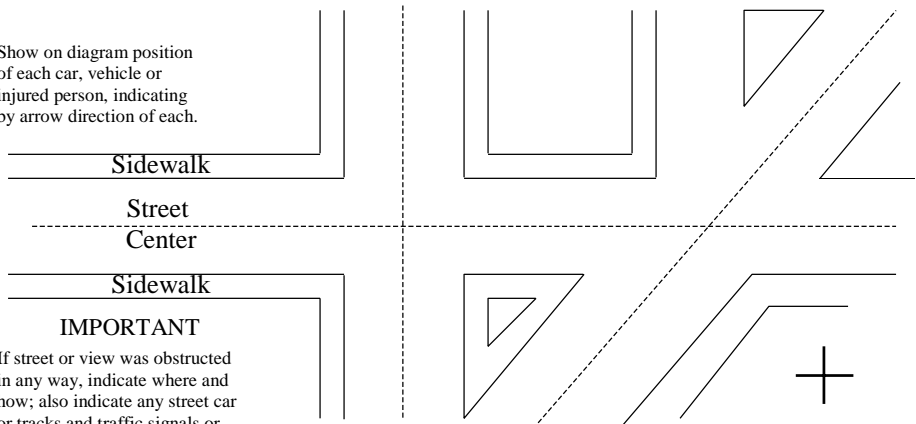
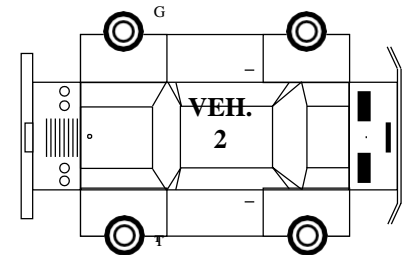
PLEASE TYPE OR PRINT IN INK

Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

CLAIMANT AND INCIDENT INFORMATION	CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)				DATE OF ACCIDENT(mm/dd/yyyy)		TIME AM <input type="checkbox"/> PM <input type="checkbox"/>			
	CURRENT STREET (RESIDENCE) ADDRESS			CITY	STATE	ZIP	PHONE HOME WORK			
	(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT			CITY	STATE	ZIP	EMAIL			
	State//County/City (if applicable) where occurred		STREET OR HWY	MILEPOST NO.	INTERSECTION OR NEAREST STREET/ROAD					
YOUR VEHICLE INFORMATION (VEHICLE #1)	YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN CAR BE SEEN?		WHEN?			
	NAME OF VEHICLE OWNER		ADDRESS		CITY	HOME AND WORK PHONE				
	NAME OF DRIVER		ADDRESS		CITY	HOME AND WORK PHONE				
	DRIVER'S LICENSE NUMBER		STATE OF ISSUANCE		DATE OF EXPIRATION					
	DESCRIBE DAMAGE				ESTIMATE \$	YOUR INSURANCE COMPANY AND POLICY NO.				
OTHER VEHICLE INFORMATION	YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOWN					
	NAME OF OWNER		ADDRESS		CITY	PHONE				
	NAME OF DRIVER		ADDRESS		CITY	PHONE				
	DESCRIBE DAMAGE						ESTIMATE \$			
	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.									
OTHER NON-VEHICLE	NAME OF OWNER		ADDRESS		CITY	PHONE				
	NAME OF OWNER		ADDRESS		CITY	PHONE				
	DESCRIBE DAMAGE						ESTIMATE \$			
INJURED PARTIES	NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
				HOME WORK						
				HOME WORK						
				HOME WORK						
				HOME WORK						
				HOME WORK						
WITNESSES	NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)		ADDRESS		CITY	PHONE				
						HOME WORK				
						HOME WORK				
						HOME WORK				

COMPLETE ALL DETAILS

Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

<p> <input checked="" type="checkbox"/> Straight Road <input checked="" type="checkbox"/> Curve – R or L <input checked="" type="checkbox"/> Level </p>	<p> <input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill </p>	<p> <input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane </p>	<p> <input type="checkbox"/> Marked Areas  </p>
<p>Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.</p>  <p align="center">IMPORTANT</p> <p>If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.</p>	<p align="center">Indicate points of compass N. E. S. W.</p>		<p>  </p>

LIGHT CONDITIONS (CHECK ONE)	TRAFFIC CONTROL	TYPE OF ROAD (CHECK ONE OR MORE)	VEHICLE CONDITION (CHECK ONE OR MORE)	ROAD SURFACE (CHECK ONE)	WEATHER (CHECK ONE)
1 <input type="checkbox"/> DAYLIGHT	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES	VEHICLE NO. 1 NO. 2 <input type="checkbox"/> 1 <input type="checkbox"/> DRY	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	<input type="checkbox"/> 2 <input type="checkbox"/> STOP SIGN	<input type="checkbox"/> 2 <input type="checkbox"/> TWO WAY	<input type="checkbox"/> 2 <input type="checkbox"/> DEFECTIVE HEADLIGHTS	<input type="checkbox"/> 2 <input type="checkbox"/> WET	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	<input type="checkbox"/> 3 <input type="checkbox"/> FLASHING RED	<input type="checkbox"/> 3 <input type="checkbox"/> REVERSIBLE ROAD	<input type="checkbox"/> 3 <input type="checkbox"/> DEFECTIVE REAR LIGHTS	<input type="checkbox"/> 3 <input type="checkbox"/> SNOW	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	<input type="checkbox"/> 4 <input type="checkbox"/> FLASHING AMBER	<input type="checkbox"/> 4 <input type="checkbox"/> INTER-CHANGE LOOP RAMP	<input type="checkbox"/> 4 <input type="checkbox"/> TIRES WORN	<input type="checkbox"/> 4 <input type="checkbox"/> ICE	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	<input type="checkbox"/> 5 <input type="checkbox"/> RR SIGNAL	<input type="checkbox"/> 5 <input type="checkbox"/> ALLEY	<input type="checkbox"/> 5 <input type="checkbox"/> PUNCTURED OR BLOWN TIRES	<input type="checkbox"/> 5 <input type="checkbox"/> OTHER (SPECIFY)	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	<input type="checkbox"/> 6 <input type="checkbox"/> OFFICER/FLAGMAN	<input type="checkbox"/> 6 <input type="checkbox"/> TWO WAY-LEFT TURN LANES	<input type="checkbox"/> 6 <input type="checkbox"/> OTHER (SPECIFY)	NAME OF INVESTIGATING POLICE AGENCY: _____ INVESTIGATING AGENCY REPORT NO. _____	
7 <input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> 7 <input type="checkbox"/> YIELD SIGN	<input type="checkbox"/> 1 <input type="checkbox"/> SEPARATED			
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED			
	<input type="checkbox"/> 9 <input type="checkbox"/> OTHER	<input type="checkbox"/> 3 <input type="checkbox"/> UNDIVIDED			

A separate claim form should be submitted for each claimant.

This information is being provided to aid in resolving the claim.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant

Date and Place (residential address, city and county)