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.

October 2017
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.
CLAIM FOR DAMAGES FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a claim for damages against the Kitsap Public Health District. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure.

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to Claims Agent
Kitsap Public Health District
345 6th Street
Suite 300
Bremerton, WA 98337

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

1. Claimant's name: 
   Last name  First  Middle  Date of birth (mm/dd/yyyy)

2. Inmate DOC number (if applicable):

3. Current residential address:

4. Mailing address (if different):

5. Residential address at the time of the incident: (if different from current address)

6. Claimant's daytime telephone number: Home Business or Cell

7. Claimant's e-mail address:

8. Date of the incident: Time:  a.m.  p.m. (check one)
    (mm/dd/yyyy)

9. If the incident occurred over a period of time, date of first and last occurrences:
   from  Time:  a.m.  p.m. (mm/dd/yyyy)
   to  Time:  a.m.  p.m. (mm/dd/yyyy)

10. Location of incident: State and county City, if applicable Place where occurred
11. If the incident occurred on a street or highway:

<table>
<thead>
<tr>
<th>Name of street or highway</th>
<th>Milepost number</th>
<th>At the intersection with or nearest intersecting street</th>
</tr>
</thead>
</table>

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 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 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 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 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 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
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 | No
---|---|---

If yes, please complete the following. If no, proceed to Section II.

**Full Name:** (Please print the name exactly as it appears on the SSN or Medicare card if available.)

**Medicare Claim Number:**

**Date of Birth (Mo/Day/Year):**

**Social Security Number:** (If Medicare Claim Number is Unavailable)

**Sex:** Female | Male

### 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**

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

**Signature of Person Completing This Form**

**Date**

*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

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

<table>
<thead>
<tr>
<th>Claimant's Name</th>
<th>(A separate form must be completed for each claimant)</th>
<th>Date of Accident (mm/dd/yyyy)</th>
<th>Time AM PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Street (Residence) Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>(Residence) Street Address for Six Months Prior to the Accident</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>State/County/City (if applicable) where occurred</td>
<td>Street or Hwy</td>
<td>Milepost No.</td>
<td>Intersection or Nearest Street/Road</td>
</tr>
<tr>
<td>Year</td>
<td>Make</td>
<td>Model</td>
<td>License Plate No.</td>
</tr>
<tr>
<td>Name of Vehicle Owner</td>
<td>Address</td>
<td>City</td>
<td>Home and Work Phone</td>
</tr>
<tr>
<td>Name of Driver</td>
<td>Address</td>
<td>City</td>
<td>Home and Work Phone</td>
</tr>
<tr>
<td>Driver's License Number</td>
<td>State of Issuance</td>
<td>Date of Expiration</td>
<td></td>
</tr>
<tr>
<td>Describe Damage</td>
<td>Estimate $</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Insurance Company and Policy No.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Make</td>
<td>Model</td>
<td>License Plate No.</td>
</tr>
<tr>
<td>Name of Owner</td>
<td>Address</td>
<td>City</td>
<td>Phone</td>
</tr>
<tr>
<td>Name of Driver</td>
<td>Address</td>
<td>City</td>
<td>Phone</td>
</tr>
<tr>
<td>Describe Damage</td>
<td>Estimate $</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was Other (Non-Vehicle) Property Damaged? If so, Describe What Type of Property Was Damaged.</td>
<td>Name of Owner</td>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Name of Owner</td>
<td>Address</td>
<td>City</td>
<td>Phone</td>
</tr>
<tr>
<td>Describe Damage</td>
<td>Estimate $</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Address</td>
<td>Phone</td>
<td>Injury</td>
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<td>Home</td>
<td>Work</td>
<td></td>
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<td>Home</td>
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<td>Home</td>
<td>Work</td>
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<tr>
<td>Name (Attach Additional Sheets if Necessary)</td>
<td>Address</td>
<td>City</td>
<td>Phone</td>
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<tr>
<td>Home</td>
<td>Work</td>
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<td></td>
</tr>
</tbody>
</table>

SF 138 (July 2009)
**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.

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**LIGHT CONDITIONS (CHECK ONE)**
1. DAYLIGHT
2. DAWN
3. DUSK
4. DARK STREET LIGHTS ON
5. DARK STREET LIGHTS OFF
6. DARK STREET LIGHTS OFF
7. OTHER (SPECIFY)

**TRAFFIC CONTROL**

<table>
<thead>
<tr>
<th>VEHICLE NO. 1</th>
<th>NO. 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SIGNALS</td>
</tr>
<tr>
<td>2</td>
<td>STOP SIGN</td>
</tr>
<tr>
<td>3</td>
<td>FLASHER RED</td>
</tr>
<tr>
<td>4</td>
<td>FLASHER AMBER</td>
</tr>
<tr>
<td>5</td>
<td>RR SIGNAL</td>
</tr>
<tr>
<td>6</td>
<td>OFFICER YIELD SIGN</td>
</tr>
<tr>
<td>7</td>
<td>NO TRAFFIC CONTROL</td>
</tr>
<tr>
<td>8</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

**TYPE OF ROAD (CHECK ONE OR MORE)**

- Straight Road
- Curve – R or L
- Level
- Hillcrest
- Uphill
- Downhill
- One Lane
- One and One-Half Lane
- Two Lane or Four Lane

**VEHICLE CONDITION (CHECK ONE OR MORE)**

- ONE WAY
- TWO WAY
- REVERSIBLE ROAD
- INTER-CHANGE LOOP RAMP
- ALLEY
- TWO WAY LEFT TURN LANES
- SEPARATED
- DIVIDED
- UNDIVIDED

**ROAD SURFACE (CHECK ONE)**

- DRY
- WET
- SNOW
- ICE
- PUNCTURED OR BLOWN TIRES
- TIRES WORN
- TIRES OTHER (SPECIFY)

**WEATHER (CHECK ONE)**

- CLEAR, CLOUDY & OVERCAST
- RAINING
- SNOWING
- FOG
- OTHER (SPECIFY)

**NAME OF INVESTIGATING POLICE AGENCY:**

INVESTIGATING AGENCY REPORT NO.

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*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)