GHCH Standard Tort Claim Form

Please *carefully read all of the information in this packet* before completing and presenting your Washington State Tort Claim. Tort claims are subject to public disclosure pursuant to RCW 42.56.

NOTE: all documents received by the Grays Harbor Community Hospital (GHCH) become the property of GHCH and **will not be returned**. Please keep a copy for your records and do not send original attachments if you may want them returned.

Presenting a Standard Tort Claim Form

RCW 4.96.020 requires citizens to present the Standard Tort Claim form to the GHCH Director of Risk Management. The law also requires GHCH to post on its website the Standard Tort Claim form with instructions. The Washington State Office of Risk Management developed the Washington State Tort Claim Form Packet, a variation of which has been adopted for use by GHCH.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Washington State Tort Claim Form
2. Standard Washington State Tort Claim Form (SF 210)
3. Medical Authorization (only for tort claims involving bodily injury)
4. Vehicle Collision Form (only for tort claims involving vehicle accidents/collisions)
5. Mandatory Medicare Beneficiary Reporting Form

Legal Requirements for Presenting Standard Tort Claim Forms

In order to verify the claim and additional supporting information, the law requires that the Standard Tort Claim 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

Present in Person or Mail the GHCH Standard Tort Claim Form & Supporting Documents to:

Grays Harbor Community Hospital
Office of Risk Management Attn:
Jason Halstead
915 Anderson Drive
Aberdeen, WA 98520

Phone (360) 537-5126

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

INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM

General Liability Claim Form #SF 210

- ✓ Before filing a Tort Claim, please read these instructions, the Tort Claim form and other appropriate forms in their entirety.
- ✓ Type or print **clearly** in ink and sign the Tort Claim 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 Tort Claim Form #SF 210:

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.

GHCH STANDARD TORT CLAIM FORM

General Liability Claim Form #SF 210

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Grays Harbor Community Hospital. Some of the information requested on this form is required by RCW 4.96.020 and is subject to public disclosure pursuant to RCW 42.56.

For Official Use Only

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to:
Grays Harbor Community Hospital
Office of Risk Management
Attn: Jason Halstead
915 Anderson Drive
Aberdeen, WA 98520

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) (mm/dd/yyyy)
   to _____ Time:_____ ☐ a.m. ☐ p.m.
   (mm/dd/yyyy) (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:

Name of street or highway	Milepost number	At the intersection with or nearest intersecting street

12. Hospital department you believe is responsible for damage/injury:

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

14. Names and telephone numbers of all hospital employees having knowledge about this incident:

15. Names 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 how the hospital caused your injuries or damages (**if your injuries or damages were not caused by the hospital, do not use this form. You must file your claim against the correct entity**). 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. Submit copies of all medical reports and billings.

_____

_____

_____

_____

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

20. I claim damages from the hospital in the sum of $_____.

This Claim form must be signed by one of the following (check appropriate box).

☐ Claimant

☐ Person holding a written power of attorney from the Claimant

☐ Attorney in fact for the Claimant

☐ Attorney admitted to practice in Washington State on the Claimant's behalf

☐ 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 Grays Harbor Community Hospital and Associated Insurance Representatives

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

Date of Birth: Month _____ Day ____ Year _____

I hereby authorize disclosure of my protected health information to Grays Harbor Community Hospital and their associated liability insurance carrier for purposes of processing my claim for damages filed with GHCH.

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)**

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

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

_____ Initials 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.

_____ Initials I understand that I may revoke this authorization at any time by notifying GHCH Risk Management in writing, and that the revocation will be effective as of the date Risk Management 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.

_____ Initials I understand that this Authorization for Release will expire 180 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 GHCH.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Risk Management.

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:

Grays Harbor Community Hospital
Office of Risk Management
915 Anderson Drive
Aberdeen, WA 98520

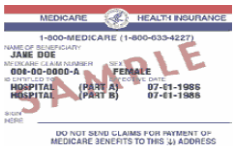
Fax: (360) 537-5039

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☐	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

Claimant Name (Please Print) **Claim Number**

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**

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 ☐ PM ☐

CURRENT STREET (RESIDENCE) ADDRESS | CITY | STATE | ZIP | HOME PHONE / WORK PHONE

(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 (VEHICLE #2)

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 DAMAGE

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.

_____

_____

_____

_____

_____

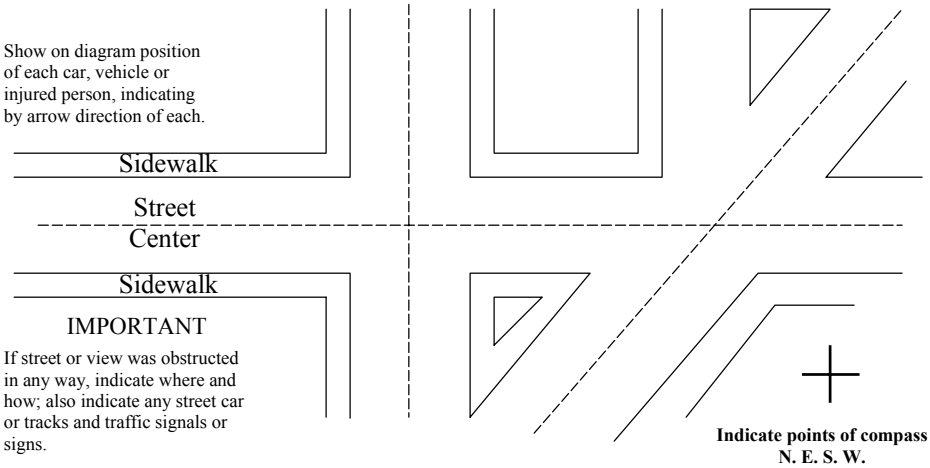
_____

☐ Straight Road
☐ Curve – R or L
☐ Level

☐ Hillcrest
☐ Uphill
☐ Downhill

☐ One Lane
☐ One and One-Half Lane
☐ Two Lane or Four Lane

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

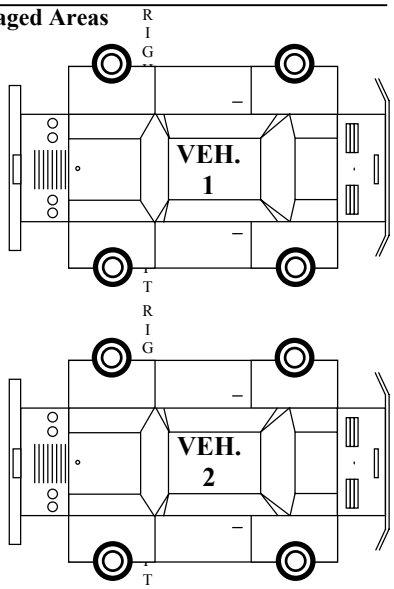


IMPORTANT

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.

Indicate points of compass
N. E. S. W.

Mark Damaged Areas



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 ☐ DAYLIGHT	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	1 ☐ CLEAR, CLOUDY & OVERCAST
2 ☐ DAWN	1 ☐ ☐ SIGNALS	1 ☐ ☐ ONE WAY	1 ☐ ☐ DEFECTIVE BRAKES	1 ☐ ☐ DRY	2 ☐ RAINING
3 ☐ DUSK	2 ☐ ☐ STOP SIGN	2 ☐ ☐ TWO WAY	2 ☐ ☐ DEFECTIVE HEADLIGHTS	2 ☐ ☐ WET	3 ☐ SNOWING
4 ☐ DARK STREET LIGHTS ON	3 ☐ ☐ FLASHING RED	3 ☐ ☐ REVERSIBLE ROAD	3 ☐ ☐ DEFECTIVE REAR LIGHTS	3 ☐ ☐ SNOW	4 ☐ FOG
5 ☐ DARK STREET LIGHTS OFF	4 ☐ ☐ FLASHING AMBER	4 ☐ ☐ INTER-CHANGE LOOP RAMP	4 ☐ ☐ TIRES WORN	4 ☐ ☐ ICE	5 ☐ OTHER (SPECIFY)
6 ☐ DARK NO STREET LIGHT	5 ☐ ☐ RR SIGNAL	5 ☐ ☐ ALLEY	5 ☐ ☐ PUNCTURED OR BLOWN TIRES	5 ☐ ☐ OTHER (SPECIFY)	
7 ☐ OTHER (SPECIFY)	6 ☐ ☐ OFFICER/ FLAGMAN	6 ☐ ☐ TWO WAY-LEFT TURN LANES	6 ☐ ☐ OTHER (SPECIFY)		
	7 ☐ ☐ YIELD SIGN	1 ☐ ☐ SEPARATED			
	8 ☐ ☐ NO TRAFFIC CONTROL	2 ☐ ☐ DIVIDED			
	9 ☐ ☐ OTHER	3 ☐ ☐ UNDIVIDED			

NAME OF INVESTIGATING POLICE AGENCY: _____

INVESTIGATING AGENCY REPORT NO. _____

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)***