Standard Tort Claim Packet

Please carefully read all of the information in this packet before completing and presenting your Standard Tort Claim.

Presenting a Standard Tort Claim Form

RCW 4.92.100 requires citizens to present the Standard Tort Claim form with the Risk Management Division (RMD). The law also required RMD to post on its website the standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, RMD developed a Standard Tort Claim Form Packet

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim form (SF 210)
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 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 Standard Tort Claim Form and Supporting Documents to:

Kris Morrison
Quality, Risk and Compliance
915 Anderson Drive
Aberdeen WA 98520

Business Hours: Monday-Friday, 7:00 am to 4 pm
Telephone Number: 360-537-5126
Closed on weekends and official state holidays

4-2015

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.

Standard Tort Claim Form

General Liability Claim Form

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against _____. Some of the information on this form is required by RCW 4.92.100 and may be subject to public disclosure. Pursuant to law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

For Official Use only
No.

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to:
Quality, Risk and Compliance
915 Anderson Drive
Aberdeen WA 98520

Business Hours are .Monday through Friday 7:30 a.m. to 4:30 p.m.
Telephone Number: 360-537-5126
Closed on weekends and official state holidays

CLAIMANT INFORMATION:

1. Claimants name: _____
   Last name First Middle Date of Birth (mm/dd/yyyy)
2. Current residential address: _____
3. Mailing address (if different) _____
4. Residential address at the time of the incident (if different from current address):
   _____
5. Claimant's daytime telephone number: Home:____-____-_____ Business: ____-____-_____
6. Claimant's e-mail address: _____

INCIDENT INFORMATION:

7. Date of the incident: ____/____/_____ (mm/dd/yyyy) Time: _____ AM PM (circle one)
8. If the incident occurred over a period of time, date of first and last occurrences:
   from ____/____/_____ Time: _____ AM PM (circle one) to____/____/_____ Time _____ AM PM (circle one)
9. Location of incident: _____
   State and County City (if applicable) Place where occurred
10. If the incident occurred on a street or highway:
    _____
    Name of street or highway Milepost Number At the intersection with or nearest intersecting street
11. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

_____ Name	____-____-____ Number	_____ Name	____-____-____ Number
_____ Name	____-____-____ Number	_____ Name	____-____-____ Number
_____ Name	____-____-____ Number	_____ Name	____-____-____ Number

12. Names, addresses and telephone numbers of Hospital employees having knowledge of this incident.

13. Names address and telephone numbers of all individuals not already identified in #11 and #12 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.

14. 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.

15. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

16. Names, address and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

17. Please attach documents which support the claim's allegations.

18. I claim damages from PHD _____ in the sum of $_____.

This Standard Tort 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 the State of Washington on the Claimant's behalf, or by a court-appointed 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)

GRAYS HARBOR COMMUNITY HOSPITAL

GRAYS HARBOR COMMUNITY HOSPITAL
915 Anderson Drive
Aberdeen, WA 98520
Health Information request line (360) 537-5196
FAX (360) 537-0588

M#

C#

Patient Name: _____ Previous Name _____
(Please Print)

Birth date: _____ SS# _____

I hereby request, authorize and direct GRAYS HARBOR COMMUNITY HOSPITAL to release my protected health information as follows:

Dates of Service: _____

To: Quality, Risk and Compliance
(Name)
915 Anderson Drive
(Address)
Aberdeen WA 98520
(City, State, Zip)

Information Requested:

- ☐ Inpatient
- ☐ Outpatient
- ☐ Last two years
- ☐ Other: _____

Purpose or need for the release:
processing my claim for damages filed with the state of Washington

Expiration Date (or event) _____
No more that 90 days from signature

Signature of patient (or representative) Date Relationship to patient

DISCLOSURES REQUIRED SPECIAL AUTHORIZATION:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for items check:

- ☐ HIV/AIDS Virus
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health/Psychiatric Disorders
- ☐ Drug, alcohol Abuse/Treatment

Signature of patient (or representative) Date Relationship to patient

This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Joint Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per our instructions the information is subject to re-disclosure and may no longer be protected by Federal Privacy rules.

For Facility Use:
Date Received: _____ Date Information Released: _____ Chart # _____

Person/Department Sending Records: _____

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		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 (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 $

OTHER NON-VEHICLE DAMAGE

WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.

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.

_____

_____

_____

_____

_____

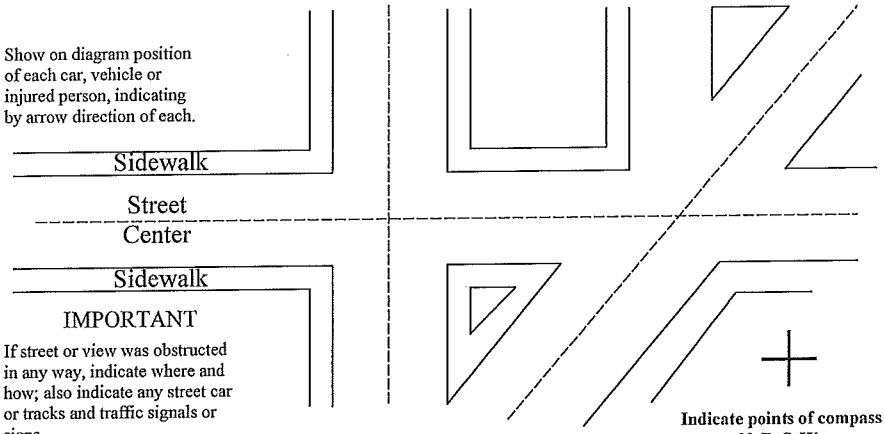
_____

☐ 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.

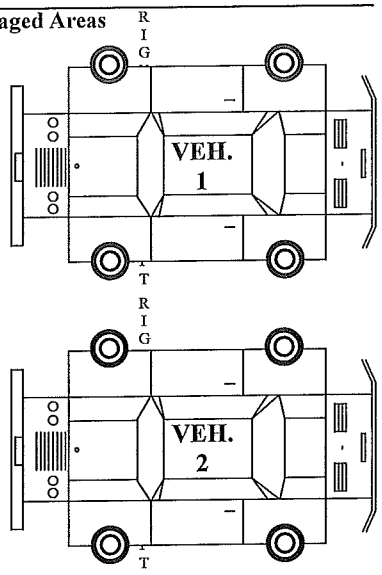


IMPORTANT

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.

_____ _____

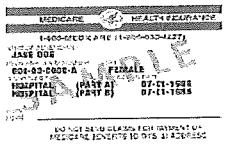
Signature of Claimant *Date and Place (residential address, city and county)*

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**