Standard Tort Claim Form Packet

Please *carefully read all of the information* before completing and submitting your Standard Tort Claim. Please note that no documents will be returned.

Legal Requirements for Presenting Standard Tort Claim Forms

In order to verify the claim and additional supporting information, the law requires that Klickitat Valley Health's Standard Tort Claim form be signed by:

- Claimant; *or*
- Person holding a written power of attorney from 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 Standard Tort Claim Form and Supporting Documents by mail or in person to:

Klickitat County Public Hospital District No. 1
Klickitat Valley Health
Leslie Heibert, CEO
310 South Roosevelt
Goldendale, WA 98620

Business Hours: Monday-Friday, 8:00 a.m. to 5:00 p.m. Closed on weekends and official state holidays.

Instructions for Completing a Tort Claim Form:

- ❑ 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 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, bills for personal injuries or 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 – 2-20-1965
2. #8092234 (for use by Department of Corrections inmates only)
3. 1234 Broadway St, Apt. 56, Goldendale, WA 98620
4. PO Box 910 Goldendale, WA 98620
5. (509) 555-5555 (509) 123-4567
6. ABSmith@hotmail.com

7. 8-9-2010 8:00 a.m.
8. 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.
9. Washington, Klickitat, Goldendale, Campus of Klickitat Valley Health, Family Medicine Clinic
10. Doe, John; Laboratory
11. Smith, John, P.O. Box 1234 Goldendale, WA 98620 (509)-773-1234. Personal friend.
12. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 10 and 11. 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.
13. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
14. Follow instructions
15. 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.
16. 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.
17. Please attach any additional documents that support your claim.
18. 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 person injury claim, please sign and attach the Authorization to Disclose Protected Health Information form.
- 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 #SF 210

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Klickitat County Public Hospital District No. 1, Klickitat Valley Health & KVH Family Medicine. Some of the information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure. Pursuant to the new law, Standard Tort Claim Forms cannot be submitted electronically (via e-mail or fax)

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to:
Klickitat County Public Hospital District No. 1
Klickitat Valley Health
Leslie Heibert, CEO
310 South Roosevelt
Goldendale, WA 98620

Business Hours: Monday-Friday, 8:00 a.m. to 5:00 p.m. Closed on weekends and official state holidays

Claimant Information

1. Claimants name: _____
   Last First Middle Date of birth
2. Current residential address: _____
3. Mailing address (if different): _____
4. Residential address at the time of the incident:_____
5. Claimant's daytime telephone number: _____(home) _____ (business)
6. Claimant's e-mail address: _____

Incident Information

7. Date of Incident:_____Time:_____ ☐a.m ☐p.m. (check one)
8. If the incident occurred over a period of time, date of first and last occurrences:
   From_____time:_____ ☐a.m ☐ p.m. to_____time:_____ ☐a.m ☐p.m.
9. Location of incident: _____
10. Person or department you believe responsible for damage/injury:
    _____
11. Names, addresses and telephone numbers of all persons involved in or witnesses to this incident:

_____

_____

_____

12. List all other witnesses having knowledge of the incident in question, with their names, addresses and telephone numbers that are not listed within items 10 and 11. Also include a description of their knowledge.

_____

_____

_____

13. Please describe the incident that resulted in the injury or damages.

_____

_____

_____

14. Describe 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? Please attach a copy of the report or contact information.

_____

_____

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

_____

_____

_____

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

18. I claim damages from Klickitat County Public Hospital District No. 1 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 & county)
Or	
_____	_____
Signature of Representative	Date and place (residential address, city & county)
_____	_____
Print Name of Representative	Bar Number (if applicable)

Authorization to Disclose Protected Health Information

Patient Name:	Date of Birth
Address:	**Dates of Service:**
Phone:	**Purpose for the release:**

Healthcare to release the information from:

_____
Name of provider, clinic or hospital

_____
Street Address City, State, Zip

_____
Phone Fax

Person or agency to release the information to:

_____
Name of provider, clinic or hospital

_____
Street Address City, State, Zip

_____
Phone Fax

The following specific information is selected to be disclosed:

☐ Medical Reports ☐ Radiology Reports ☐ Labs
☐ Billing Statement ☐ Radiology Films ☐ Other_____

The information that is disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, federal or state law may restrict re-disclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

***The following items must be initialed to be included in the use/disclosure of other medical information:**

_____*AIDS/HIV and other Communicable Diseases
_____*Behavioral health Care/Psychiatric Care/Mental Health Information
_____*Alcohol and/or Drug Abuse
_____*Genetic Testing Information

The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Klickitat Valley Health Medical Records Department and state that you are revoking this authorization.

I have read this authorization and I understand it. This authorization expires in 90 days from the date signed unless otherwise specified.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name (proof of authority to sign may be required) Relationship to Patient

_____
Witness

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

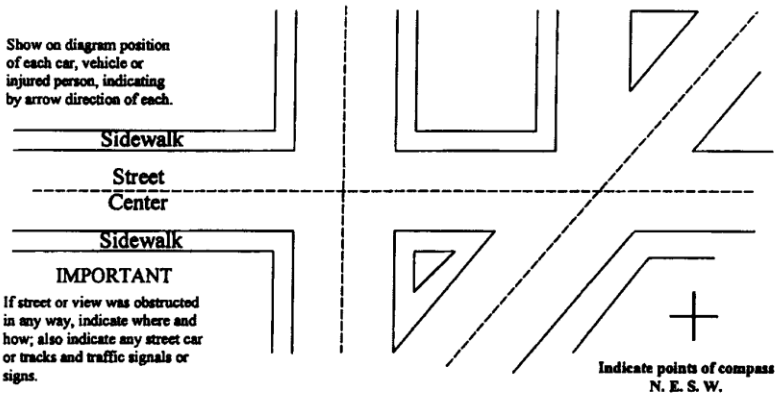
HOME WORK

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

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

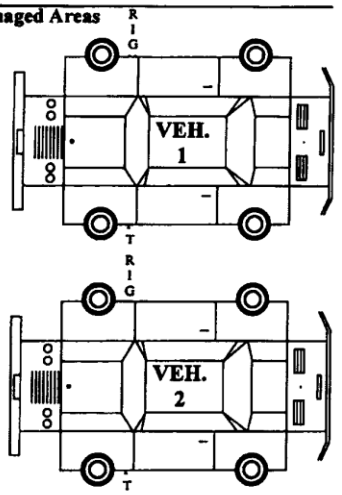


IMPORTANT

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	
4 ☐ DARK STREET LIGHTS ON	3 ☐ ☐ FLASHING RED	3 ☐ ☐ REVERSIBLE ROAD	3 ☐ ☐ DEFECTIVE REAR LIGHTS	3 ☐ ☐ SNOW	3 ☐ SNOWING
5 ☐ DARK STREET LIGHTS OFF	4 ☐ ☐ FLASHING AMBER	4 ☐ ☐ INTER-CHANGE LOOP RAMP	4 ☐ ☐ TIRES WORN	4 ☐ ☐ ICE	4 ☐ FOG
6 ☐ DARK NO STREET LIGHT	5 ☐ ☐ RR SIGNAL	5 ☐ ☐ ALLEY	5 ☐ ☐ PUNCTURED OR BLOWN TIRES	5 ☐ ☐ OTHER (SPECIFY)	5 ☐ OTHER (SPECIFY)
7 ☐ OTHER (SPECIFY)	6 ☐ ☐ OFFICER/ FLAGMAN	6 ☐ ☐ TWO WAY-LEFT TURN LANES	6 ☐ OTHER (SPECIFY)		
	7 ☐ ☐ YIELD SIGN	☐ 1 ☐ SEPARATED		NAME OF INVESTIGATING POLICE AGENCY	
	8 ☐ ☐ NO TRAFFIC CONTROL	☐ 2 ☐ DIVIDED		INVESTIGATING AGENCY REPORT NO.	
	9 ☐ ☐ OTHER	☐ 3 ☐ 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

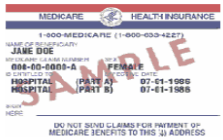
Date and Place (residential address, city and county)

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**