Clallam County Hospital District #1Tort Claim Form Packet

Please *carefully read all the information in this packet* before completing and presenting your Clallam County Hospital District #1 (CCHD#1) Tort Claim. Tort claims are subject to public disclosure pursuant to RCW 42.56.

NOTE: all documents received by the Risk Manager become the property of CCHD#1 and **will not be returned**. Please keep a copy for your records and do not send original attachments as they will not be returned.

Presenting a Standard Tort Claim Form

RCW 4.96.020 requires citizens to present a standard Tort Claim form with the agent appointed to receive such claims. The law also requires CCHD#1 to make available the Tort Claim form with instructions.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Clallam County Hospital District #1 Tort Claim Form
2. Standard Clallam County Hospital District #1 Tort Claim Form (Tort Claim Form.FCH8710.20190919)
3. Medical Authorization (only for tort claims involving bodily injury)

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, Mail, Fax or Email the Clallam County Hospital District #1 (CCHD#1) Tort Claim Form & Supporting Documents to:

Risk Manager
Clallam County Hospital District #1
530 Bogachiel Way
Forks, WA 98331
Phone (360) 327-8329
Fax (360) 374-3166
Email: claimsform@forkshospital.org

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 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:

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 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.

CLALLAM COUNTY HOSPITAL DISTRICT #1 TORT CLAIM FORM

General Liability Claim Form #SF 210

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Clallam County Hospital District #1 (CCHD#1). 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

Risk Manager
Clallam County Hospital District #1
530 Bogachiel Way
Forks, Washington 98331
Phone: (360) 327-8328
Fax: (360) 374-3166
Email: claimsform@forkshospital.org

Business Hours: Monday – Friday 8:00 a.m. – 5:00 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. 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 Clallam County Hospital District #1 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 Clallam County Hospital District #1 (CCHD#1) caused your injuries or damages (**if your injuries or damages were not caused by the Clallam County Hospital District #1 (CCHD#1), 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 Clallam County Hospital District #1 (CCHD#1) 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)***

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Authorization for Release of Protected Health Information (PHI)
to
Clallam County Hospital District #1, Office of Risk Management

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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 Clallam County Hospital District #1 Office of Risk Management (Risk Management) for purposes of processing my claim for damages filed with the Clallam County Hospital District #1.

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)**

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

_____ (initial) I understand that my health information may be subject to re-disclosure by Risk Management and not protected for purposes of evaluating and investigating the claim I have filed with the Clallam County Hospital District #1.

_____ (initial) 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

_____ (initial) I understand that I may revoke this authorization at any time by notifying 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.

_____ (initial) 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 CCHD#1 Risk Management.

A Photocopy 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:

Risk Manager
Clallam County Hospital District #1
530 Bogachiel Way
Forks, WA 98331
Phone (360) 327-8329
Fax (360) 374-3166
Email: claims@forkshospital.org