

Standard Tort Claim Form Packet

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

A Law that Impacts Presenting a Standard Tort Claim Form

RCW 4.96 addresses how tortious claims are to be filed with Columbia County. Among the requirements are that Columbia County appoint an agent to receive any claim made under RCW 4.96 and that the County present a Standard Tort Claim form for these purposes. In compliance with these requirements and for the convenience of citizens, Columbia County has developed a Standard Tort Claim Form Packet. This form is to be received by the Columbia County Risk Manager.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Vehicle Collision Form only for tort claims involving vehicle accidents/collisions

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:

Columbia County Risk Manager
415 N. Guernsey Ave.
P.O. Box 5
Dayton, WA 99328

Business Hours: Monday – Friday 7:30 a.m. to 4:30 p.m.
Closed for lunch, weekends, and official State holidays

Instructions for Completing a Standard Tort Claim Form

Before presenting a Standard Tort Claim form, please read these instructions, the Standard Tort Claim form, and other appropriate forms in their entirety.

Type or print clearly in ink and sign the Standard Tort Claim form.

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 Standard Tort Claim form can be easily read and understood.

The following are examples on how to complete the Standard Tort Claim form:

1. Smith, Karen Michelle
2. 111 Columbia Rd. Dayton, WA 99328
3. P.O. Box 910, Dayton WA 99328
4. Same (or residence at the time of incident)
5. 509-123-4567
6. KMS@localinternet.com
7. 8:00 a.m., August 9, 2008
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 7.
9. Washington, Columbia, Dayton, County Courthouse.
10. Columbia Rd., near 323 Columbia Rd. by the intersection of Starbuck Rd.
11. Sherriff's Office
12. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Walla Walla WA 99362 (509) 456-3456; Tow Truck Driver, U-Wreck'em Towing.
13. Unknown
14. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 11 and 12. 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.
15. 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.
16. Please describe the incident that resulted in the injury or damages, specifically answering the questions of 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 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 presenting a personal injury claim, please sign and attach the Medical Release form.

If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision form.

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Columbia County. 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 law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

Mail or Deliver Original Claim to:

Columbia County Risk Manager
415 N. Guernsey Ave.
P.O. Box 5
Dayton, WA 99328

Business Hours: Monday – Friday 7:30 a.m. to 4:30 p.m.
Closed for lunch, weekends, and official State holidays

PLEASE TYPE OR PRINT IN INK

Claimant Information:

1. Claimant's 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: _____ Time: _____ a.m. p.m.
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: _____
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. County agency or department alleged responsible for damage/injury:

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

13. Names, addresses and telephone numbers of all County employees having knowledge about this incident:

14. Names, addresses and telephone numbers of all individuals not already identified in #12 and #13 above that have knowledge regarding the liability issues 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.

15. 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.

16. Has the incident been reported to law enforcement, safety, or security personnel? If so, when and by whom?

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

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

19. I claim damages from Columbia County 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)

Claim # _____

**Authorization for Release of Protected Health Information (PHI)
To
Columbia County Risk Management**

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

Date of Birth: Month _____ Day _____ Year _____

I hereby authorize the disclosure of my protected health information to the Columbia County Risk Manager for purposes of processing my claim for damages filed with Columbia County.

I understand that by signing this document, I authorize the release of the following information:

Complete medical records 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 assessments, testing, referral or treatment records.

Pharmacy prescriptions and reports.

All letters and memos received or sent, including electronic mail, referencing my 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 Columbia County and not protected for purposes of evaluating and investigating the claim I have filed with Columbia County,

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 Columbia County in writing, and that the revocation will be effective as of the date Columbia County receives it. Any records obtained pursuant to the Authorization for Release of PHI prior to the revocation will be deemed authorized by me for release.

Initials I understand that the 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 Columbia County.

A photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Columbia County.

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:

Columbia County Risk Manager
415 N. Guernsey Ave.
P.O. Box 5
Dayton, WA 99328

STANDARD VEHICLE ACCIDENT TORT CLAIM FORM

PLEASE TYPE OR PRINT IN INK

Pursuant to RCW 4.92, this form is provided for your convenience when filing a tort claim against the State of Washington involving an accident with a vehicle being operated by a state employee.

Office of Financial Management

**Risk Management Division
300 General Administration Building
Post Office Box 41027, MS: 41027
Olympia, Washington 98504-1027**

Mail or deliver original claim in duplicate to:

For Official Use Only

This Claim Form cannot be submitted electronically (via e-mail or fax)

CLAIMANT AND INCIDENT INFORMATION	CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)				DATE OF ACCIDENT			TIME AM <input type="checkbox"/> PM <input type="checkbox"/>				
	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.

<input type="checkbox"/> Straight Road	<input type="checkbox"/> Hillcrest	<input type="checkbox"/> One Lane
<input type="checkbox"/> Curve – R or L	<input type="checkbox"/> Uphill	<input type="checkbox"/> One and One-Half Lane
<input type="checkbox"/> Level	<input type="checkbox"/> Downhill	<input type="checkbox"/> 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 <input type="checkbox"/> DAYLIGHT	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	<input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS	<input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY	<input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES	<input type="checkbox"/> 1 <input type="checkbox"/> DRY	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	<input type="checkbox"/> 2 <input type="checkbox"/> STOP SIGN	<input type="checkbox"/> 2 <input type="checkbox"/> TWO WAY	<input type="checkbox"/> 2 <input type="checkbox"/> DEFECTIVE HEADLIGHTS	<input type="checkbox"/> 2 <input type="checkbox"/> WET	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	<input type="checkbox"/> 3 <input type="checkbox"/> FLASHING RED	<input type="checkbox"/> 3 <input type="checkbox"/> REVERSIBLE ROAD	<input type="checkbox"/> 3 <input type="checkbox"/> DEFECTIVE REAR LIGHTS	<input type="checkbox"/> 3 <input type="checkbox"/> SNOW	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	<input type="checkbox"/> 4 <input type="checkbox"/> FLASHING AMBER	<input type="checkbox"/> 4 <input type="checkbox"/> INTER-CHANGE LOOP RAMP	<input type="checkbox"/> 4 <input type="checkbox"/> TIRES WORN	<input type="checkbox"/> 4 <input type="checkbox"/> ICE	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	<input type="checkbox"/> 5 <input type="checkbox"/> RR SIGNAL	<input type="checkbox"/> 5 <input type="checkbox"/> ALLEY	<input type="checkbox"/> 5 <input type="checkbox"/> PUNCTURED OR BLOWN TIRES	<input type="checkbox"/> 5 <input type="checkbox"/> OTHER (SPECIFY)	
7 <input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> 6 <input type="checkbox"/> OFFICER/FLAGMAN	<input type="checkbox"/> 6 <input type="checkbox"/> TWO WAY-LEFT TURN LANES	<input type="checkbox"/> 6 <input type="checkbox"/> OTHER (SPECIFY)		
	<input type="checkbox"/> 7 <input type="checkbox"/> YIELD SIGN	<input type="checkbox"/> 1 <input type="checkbox"/> SEPARATED		NAME OF INVESTIGATING POLICE AGENCY: _____	
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED		INVESTIGATING AGENCY REPORT NO. _____	
	<input type="checkbox"/> 9 <input type="checkbox"/> OTHER	<input type="checkbox"/> 3 <input type="checkbox"/> UNDIVIDED			

I do hereby claim damages from the State of Washington in the sum of \$ _____.

A separate claim form should be submitted for each claimant. The Claimant must sign this claim form unless he or she is incapacitated, a minor, or a nonresident of the state, in which case it may be signed on behalf of the Claimant by any relative, attorney, or agent representing 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)