PORT OF OLYMPIA | TORT CLAIM FORM PACKET

Please carefully read all of the information in this packet before completing and submitting your Standard Tort Claim Form ("Claim Form"). Please note that no documents will be returned.

Documents Contained in the Claim Form

1. Instructions for completing the Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Mandatory Medicare Beneficiary Reporting Form

Presenting a Tort Claim Form

Washington law requires citizens wishing to bring a claim against a local government entity to first present a tort claim form with the government at issue. The law also requires government entities to provide citizens with access to the tort claim form with instructions. In compliance with these requirements and for the convenience of citizens, the Port has prepared the following standard Claim Form.

Legal Requirements for Presenting a Tort Claim Form

In order to verify the claim and additional supporting information, the Claim Form must be signed by either:

1. The claimant;
2. A person holding a written power of attorney from the claimant;
3. An attorney admitted to practice in Washington State on the claimant's behalf; or
4. A court-approved guardian or guardian ad litem on behalf of the claimant.

Forms presented without proper signature will be rejected. Please be sure to type or print clearly in ink.

Submit the Claim Form and Supporting Documents by Mail or Email To:

Port of Olympia
Attn: Jeri Sevier
606 Columbia Street NW, Suite 300
Olympia, Washington 98501
jeris@portolympia.com

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 Claim Form, please read these instructions, the Claim Form, and other appropriate forms in their entirety.

- ✓ Type or print clearly in ink and sign the 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 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 Claim for Damage form:

(1) Doe, John Conner, 12/01/1910

(2) 222 One Way Street, Apt. Z, Olympia, Washington 98501

(3) Post Office Box 111, Olympia, Washington 98501

(4) Same

(5) (360) 555-5555

(6) January 1, 2009, 8:00 a.m.

(7) 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).

(8) Washington, Thurston, Tumwater, parking lot of Port of Olympia offices.

(9) **Incident claims will only be accepted if they occurred on Port of Olympia property, not public streets or highways outside the Port of Olympia boundaries.**

(10) Submit this claim only if the incident occurred on Port of Olympia property.

(11) Fitzgerald III, Mortamer, 3287 Wonderful Lane, Olympia, Washington 98501, (360)111-1111; tow truck driver, XYZ Towing.

(12) Unknown

(13) 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.

(14) Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.

(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 medical records and bills.

(17) Attach documents which support the claim's allegations.

(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.

(19) If you were injured, please complete a Medicare Verification form.

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Port of Olympia. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Pursuant to law, this tort claim form cannot be submitted electronically

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 for Six Months Prior to the Date of the Incident (if different from current address):

_____

(5) Claimant's Daytime Phone Numbers: Home Phone # _____, Business/Cell #_____,
Claimant's Email Address: _____

INCIDENT INFORMATION

(6) Date of Incident: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)

(7) If the incident occurred over a period of time, date of first and last occurrences:
From: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)
To: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)

(8) Location of Incident: _____
(city/state) (place where occurred)

(9) If the incident occurred on a street within the Port of Olympia boundaries:

_____
(name of street) (at intersection with or nearest intersecting street)

(10) District or agency alleged responsible for damage/injury: Port of Olympia

(11) Names, address, and telephone numbers of all persons involved in or witness to this incident:

_____
_____

(12) Name, addresses, and telephone numbers of all district or agency employee having knowledge about this incident:

_____

_____

(13) Names, addresses, 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, addresses 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 in the amount of $_____

(19) If you are injured, are you a Medicare beneficiary? ❑Yes ❑No (check one) If Yes, please complete the Medicare Verification form.

****ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY****

License Plate # _____ Driver License # _____

Type Auto: _____
(year) (make) (model)

DRIVER: _____ **OWNER:** _____
Address: _____ Address: _____
_____ _____
Phone #: _____ Phone #: _____

PASSENGERS:
Name: _____ Name: _____
Address: _____ Address: _____
_____ _____

NOTE: THIS FORM MUST BE SIGNED BY THE CLAIMANT, A PERSON HOLDING A WRITTEN POWER OF ATTORNEY FROM 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.

x _____ _____
SIGNATURE OF CLAIMANT DATE AND PLACE (ADDRESS, CITY AND COUNTY)

OR

x _____ _____
Signature of Representative Date and place (address, city and county)

_____ _____
Print name of Representative Bar Number (if applicable)

Authorization for Release of Protected Health Information (PHI)
to
Department of Enterprise Services, Office of Risk Management

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 Department of Enterprise Services, Office of Risk Management (Risk Management) for purposes of processing my claim for damages filed with the state of Washington.

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 Risk Management and not protected for purposes of evaluating and investigating the claim I have filed with the state of Washington.

_____ 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 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 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 RMD.

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:

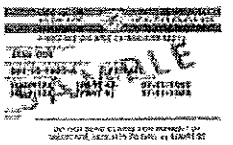
Department of Enterprise Services
Office of Risk Management
1500 Jefferson Street SE
Olympia, WA 98504-1466
Fax: 360-407-8022
Email: WashingtonStateTortClaimE-Filing@des.wa.gov

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**