Tort Claim Form Packet

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

Presenting a Standard Tort Claim Form

RCW4.96.020 requires citizens to present the Standard Tort Claim form to the Kennewick Public Hospital District's designated agent. The designated agent for the Kennewick Public Hospital District is the hospital CEO. The deputy agent, who may also receive the Standard Tort Claim form, is the CEO's Executive Assistant.

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. 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 is 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:

Kennewick Public Hospital District
Attn: CEO
3730 Plaza Way
P.O. Box 6128
Kennewick, WA 99336

Business Hours: Monday-Friday, 9:00 a.m. to 4:00 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.

- ✓ 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 damage, 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 compete the Tort Claim Form:

1) Smith, Karen Michelle -02/20/1965
2) 123456 W. Kennewick Ave., Kennewick WA 99336
3) PO Box 123, Kennewick WA 99336
4) Same (or residence at the time of incident)
5) (509) 123-4567 – (509) 987-6543
6) KMSmith@hotmail.com
7) 8/9/2010 8:00 a.m.
8) If the incident that caused the damage occurred over a period of time, please provide the beginning time and the ending time in item 8.
9) Washington, Benton County, Kennewick, Kennewick General Hospital Emergency Department. Auburn St. at intersection with 8th Ave.
10) Auburn St. at intersection with 8th Ave.
11) Smith, Thomas Arthur, 123456 W. Kennewick Ave., Kennewick WA 99336 (509) 123-4567
12) Dr. Smith, Nurse Adams, Nurse Jones, Kennewick General Hospital
13) List all other witnesses having knowledge of the incident in question, with their names, Address 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.
14) Please describe the incident that resulted in the injury or damages, especially 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 of 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 record 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 personal injury claim, please sign and attach the Medical Release.

Pursuant to Chapter 4.96 RCW this form is to be utilized to file a tort claim against Kennewick Public Hospital District. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Pursuant to the law, Standard Tort Claim form cannot be submitted electronically (via email or fax).

PLEASE TYPE OR PRINT CLEARLY IN INK
Mail deliver original claim to:

Kennewick Public Hospital District
Attn: CEO
3730 Plaza Way
P.O. Box 6128
Kennewick, WA 99336

Business Hours: Monday – Friday 9:00 a.m. – 4:00 p.m.
Closed on weekends and official state holidays

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

   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 intersection street

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

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

13. Names, addresses 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.

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? 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 the Kennewick Public Hospital District in the sum of $_____

The 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)
Or	
_____	_____
Signature of Representative	Date and place (residential address, city and county)
_____	_____
Print Name of Representative	Bar Number (if applicable)

Authorization for Release of Protected Health Information (PHI)
To
Kennewick Public Hospital District

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 Kennewick Public Hospital District, for purposes of processing my claim for damages filed with the Kennewick Public Hospital District.

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)

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

_____I understand that my health information may be subject to re-disclosure by the Kennewick Public Hospital District and not protected for purposes of evaluating and investigating the claim I have filed with the state of Washington.

_____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.

_____I understand that I may revoke this authorization at any time by notifying the Kennewick Public Hospital District in writing, and that the revocation will be effective as of the date the Kennewick Public Hospital District 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.

_____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 the Kennewick Public Hospital District.

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:
Kennewick Public Hospital District
Risk Manager
3730 Plaza Way
P.O. Box 6128
Kennewick, WA 99337

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 I, 2009, requires that liability insurers (including self-insurers), 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.

Section I

Are you presently, or have you even 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 or 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 _____