Bainbridge Island Metro Park & Recreation District

Tort Claim Packet

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

NOTE: All documents received by Bainbridge Island Metro Park & Recreation District (Park District) become the property of the Park District and will not be returned. Please keep a copy for your records and do not send original attachments if you may want them returned.

Documents Contained in the Tort Claim Form Packet

1. Instructions for completing the Park District Tort Claim Form
2. Park District Tort Claim Form
3. Authorization for Release of Protected Health Information (only for claims involving bodily injury)
4. MMSEA Reporting Compliance Declaration (only for claims involving bodily injury and a Medicare beneficiary)

Legal Requirements for Presenting Tort Claim Form

In order to verify the claim and additional supporting information, the law requires that the Tort Claim form be signed by:

- Claimant; or
- Attorney in fact for the Claimant pursuant to written power of attorney; 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

Mail the Tort Claim Form & Supporting Documents to:

Bainbridge Island Metro Park & Recreation District
Attn: Executive Director
7666 NE High School Road
Bainbridge Is, WA 98110
Phone: 206-842-2306

Due to Governor Inslee's "Stay Home, Stay Healthy" order and subsequent closure of the Park District's Administrative Office, at this time Tort Claim forms will only be accepted by mail using the address listed above.

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 forms 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 damages, receipts for property value, etc.
- ✓ If the requested information can not be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

- ✓ The following are examples of how to complete the Tort Claim form:
  1. Smith, Jane Denise – 01/01/1989
  2. #395892 (for use by Department of Corrections inmates only)
  3. 1234 Main Street, Apt. Z, Bainbridge Is, WA 98110
  4. P.O. Box 678, Bainbridge Is, WA 98110
  5. Same (or residence at the time of incident)
  6. 206-555-4321 – 206-555-9876
  7. jdsmith@hotmail.com
  8. 7/1/2015 7:00am
  9. If the incident that caused damages occurred over a period of time, please provide the beginning and ending time.
  10. Washington, Kitsap, Bainbridge Island, Central Park
  11. Highway 305, Milepost 11, near XYZ Rd
  12. Bainbridge Island Metro Park & Recreation District
  13. Smith, John Lucas, 1234 Main Street, Apt. Z, Bainbridge Is, WA 98110, 206-555-2468
  14. If known, provide the name of Park District employees with knowledge of the incident in question.
  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.
  16. Please describe the incident that resulted in 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 personal injury, please include your medical records and bills.
  19. Attach documents which support the claim's allegations.
  20. Indicate yes or no. If yes, please complete and attach the Authorization for Release of Protected Health Information.
  21. Indicate yes or no. If yes, please complete and attach the MMSEA Reporting Compliance Declaration.
  22. 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 complete and attach the Authorization for Release of Protected Health Information.
  - ✓ If you are filing a personal injury claim and are a Medicare beneficiary, please complete and attach the MMSEA Reporting Compliance Declaration.

TORT CLAIM FORM

PLEASE TYPE OR PRINT CLEARLY IN INK

Deliver to:

Bainbridge Island Metro Park & Recreation District
Attn: Executive Director
7666 NE High School Road
Bainbridge Is, WA 98110
Phone: 206-842-2306

Due to Governor Inslee's "Stay Home, Stay Healthy" order and subsequent closure of the Park District's Administrative Office, at this time Tort Claim forms will only be accepted by mail using the address listed above.

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 time of the incident: _____
   (if different from current address)
6. Claimant's daytime phone number: _____ _____
   Home Business or cell
7. Claimant's email address: _____
8. Date of incident: _____ Time: _____ ☐ am ☐ pm (check one)
   (mm/dd/yyyy)
9. If incident occurred over a period of time, date of first and last occurrence:

   From: _____ Time: _____ ☐ am ☐ pm (check one)
   (mm/dd/yyyy)

   To: _____ Time: _____ ☐ am ☐ pm (check one)
   (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. District of agency alleged responsible for damage/injury:

_____

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

_____

_____

_____

14. Names and telephone numbers of all Park District 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 Park District caused your injuries or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

_____

_____

_____

_____

_____

_____

17. Has the 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. Were you injured in the incident in question? _____ YES _____ NO. If YES, please complete the Authorization for Release of Protected Health Information.
21. If you are injured, are you a Medicare beneficiary? _____ YES _____ NO. If YES, please complete the MMSEA Reporting Compliance Declaration.
22. I claim damages from the Park District in the sum of $ _____.

This claim form must be signed by one of the following (check appropriate box).

☐ Claimant
☐ Attorney in fact for the Claimant pursuant to written power of attorney
☐ 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 and Relationship to Claimant	**Bar Number (if applicable)**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) to Bainbridge Island Metro Park & Recreation 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 Bainbridge Island Metro Park & Recreation District (Park District) 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 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 or 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 government 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 the Park District and not protected for purposes of evaluating and investigating the claim I have filed with the state of

Washington.

____ initials I understand that specific information to be disclosed in my medical records 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 the Park District in writing, and that the revocation will be effective as of the date the Park 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.

____ 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 the Park District.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to the Park District.

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 a minor
- ☐ Legal Guardian
- ☐ Personal Representative
- ☐ Other:

_____

To the Provider or Records Custodian:

Please send legible copies of all records to:

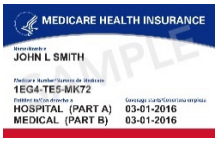
Bainbridge Island Metro Park & Recreation District
Attn: Executive Director
7666 NE High School Road
Bainbridge Is, WA 98110
Phone: 206-842-2306

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 payments, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary and recover 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 information requested. I understand that if I am a Medicare beneficiary and 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.

_____

_____

_____

_____ _____

Signature of Person Completing This Form **Date**