Standard Tort Claim Form Packet

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

A new law that impacts presenting a Standard Tort Claim form

RCW 4.6.020, requires citizens to present the Standard Tort Claim form with the government entity named in their claim. The law requires local government entities to provide the Standard Tort Claim form with instructions on how to complete the form. In compliance with these requirements and for the convenience of citizens, the State Office of Financial Management (OFM) developed a Standard Tort Claim form packet. The Standard Tort Claim form may be submitted directly to Woodinville Fire & Rescue.

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 (for tort claims involving vehicle accidents/collisions)
- 5. 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 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:

Via Mail: Fire Chief Woodinville Fire & Rescue P.O. Box 2200 Woodinville, WA 98072-2200 Via Delivery:
Fire Chief
Woodinville Fire & Rescue
17718 Woodinville Snohomish Rd NE
Woodinville, WA 98072-8509

Business Hours: Monday - Friday

8:00 a.m. - 5:00 p.m.

Closed on weekends and 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. Doe, John
 - 2. 1234 XYZ St., Apt. 01, Anycity, State Zipcode
 - 3. PO Box 123, Anycity, State Zipcode
 - 4. Same (or residence at the time of incident)
 - 5. (Area Code) 123-4567
 - 6. Email address
 - 7. 8:00 a.m., January 10, 2020
 - 8. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time.
 - 9. Washington, King, City, Woodinville Fire & Rescue Fire Station No., parking lot
 - 10. If applicable, I-5, Southbound, mile post 000, near the XYZ exit
 - 11. Woodinville Fire & Rescue
 - 12. Dow, Jane, 1234 ABC St., Anycity, State Zipcode, (Area Code) 123-4567; Tow truck driver; Tow Truck Company
 - 13. List employee names if known or enter "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 12 and 13. 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 describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when, and why.
 - 16. If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information for the person with whom you spoke.
 - 17. Please provide a list of all medical providers including names, addresses, telephone numbers, and the type of treatment provided. If you were treated for a personal injury, please include your medical records and bills.
 - 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 4.96 RCW, this form is for filing a tort claim against Woodinville Fire & Rescue. 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 new law, Standard Tort Claim forms cannot be submitted electronically (via email or fax).

PLEASE TYPE OR PRINT IN INK	For Official Use Only
Mail or deliver to: Fire Chief Woodinville Fire & Rescue 17718 Woodinville Snohomish Rd NE Woodinville, WA 98072-8509 Business Hours: Monday - Friday, 8:00 a.m 5:00 p.m. Closed on weekends and holidays CLAIMANT INFORMATION	No.
1. Claimant's name:	
Last name First name Middle name	Date of birth (m/dd/yyyy)
2. Current residential address:	
3. Mailing address (if different):	
4. Residential address at the time of the incident (if different from current a	address):
5. Claimant's daytime telephone number:	Business
6. Claimant's email address:	
INCIDENT INFORMATION	
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 occur	rences:
from Time: a.m. p.m. to	Time: a.m p.m.
9. Location of incident:	
State, County and City, if application 10. If the incident occurred on a street or highway:	cable place where occurred
Name of street or highway, mile post number, intersection with	or nearest intersecting street
11. State/local agency or department allegedly responsible for damage/injur	ry:
12. Names, addresses, and telephone numbers of all persons involved in or	witness to this incident:

13. Names, addresses, and telephone numbe	ers of all state employees having knowledge of this incident:
knowledge regarding the liability issues invol	ers of all individuals not already identified in #12 and #13 above who have ved in this incident or knowledge of the Claimant's resulting damages. Please and extent of each person's knowledge. Attach additional sheets if necessary.
 Describe the cause of the injury or damage injuries. Attach additional sheets if necessary 	ge(s). Explain the extent of property loss or medical, physical or mental
	f
attach a copy of the report or contact inform	iforcement, safety, or security personnel? If so, when and to whom? Please ation.
17. Names, addresses, and telephone numbe billings.	ers of treating medical providers. Attach copies of all medical reports and
18. I claim damages from Woodinville Fire &	
	ant, a person holding a written power of attorney from the Claimant, by the ney admitted to practice in Washington State on the Claimant's behalf, or by a
declare under penalty of perjury under the l	aws of the State of Washington that the foregoing is true and correct.
Signature of Claimant	Date and place (residential address, city and county)
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 Woodinville Fire & Rescue

Name:				
	Last	Firs	st	Middle initial or middle name
Date of Birth:	Month	Day	Year	
•				h information to Woodinville Fire & Rescue for purposes of wille Fire & Rescue.
I understand t	hat by signing t	this docum	ent, I author	rize the release of the following information:
patient admis	sions; operative stant orders; nu	e notes; ph	ysical or oth	nistory and physical exam; progress notes; x-ray reports; in her therapy; laboratory and other test reports; physician and her records and references designated by the provider as part
HIV test result	ts and medical i	nformation	n related to I	HIV testing or treatment.
=				including treatment notes, assessments, testing documents health diagnosis and treatment.
Alcohol assess	sment, testing,	referral or	treatment re	ecords.
All other chen	nical dependen	cy assessm	ent of treatr	ment records, pharmacy prescriptions and reports.
			_	ectronic mail, referencing my treatment. Information related ease, including test results.
Urgent care, o	outpatient or ot	her clinic v	isit informat	tion.
Gynecological	and/or obstetr	ical inform	ation.	
All client reco agency:	rds generated f	or or by go	vernmental	programs of which I am a client. Identify the program(s) by
Financial reco	rds related to n	ny care and	d treatment.	

Form: Tort Claim Packet

Authorization for Release of Protected Health Information (PHI) to Woodinville Fire & Rescue

I understand the following: (Please read and initial all statements)

	at my records are protected uate Health Care Information Ac	nder HIPAA/PHI regulations (federal lavet (RCW 70.02).	v) and the
I understand th	at my health information may	be subject to re-disclosure by Wooding and investigating the claim I have filed	
information reg	•	be disclosed in my medical record may controlled substance use, counseling remune deficiency syndrome.	
writing, and the Any records ob	at the revocation will be effect	tion at any time by notifying Woodinvillive as of the date Woodinville Fire & Reization for Release of PHI prior to the re	escue receives it.
authorize a diff		ise will expire 90 days from the date I si use to be valid. This permission is valid u cue.	=
A photocopy of this Autho to Woodinville Fire & Reso		ority as the original for purposes of rele	asing my records
Signature of Authorizing Inc	lividual	Date of Signature	
Telephone Number			
Witness (where patient is o	ver 13 and signing the release)		
Where the signer is not t	he subject of the records:		
I am authorized to sign th	is because I am the (attach pro	oof of authority):	
Parent of minor	Legal Guardian	Personal Representative	Other
To the provider or record	s custodian: Please send legib	le copies of all records to:	
Via Delivery		Via Mail	
Fire Chief		Fire Chief	
Woodinville Fire & Rescue 17718 Woodinville Snoho Woodinville, WA 98072-8	mish Rd NE	Woodinville Fire & Rescue P.O. Box 2200 Woodinville, WA 98072-2200	

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Form: Tort Claim Packet

Vehicle Collision Form

Please type or print in ink

Please attach this form to your Standard Tort Claim form if the claim involves a vehicle collision.

Complete All Details

Describe the 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. A separate claim form must be submitted for each

clai	mant.				
	Claimant Name (a separate form must be completed for each claimant)	Date of Acc	cident (mm/dd/yyy)	Time	AM
tion					PM
Claimant and Incident Information	Current Street (residence) Address	City		State	Zip
t Info					
ident	Phone - Cell Phone - Home Phone - Work		Email		
d Inc					
ıt an	Street (residence) Address for 6 months prior to the accident	City		State	Zip
imar					
C	State/County/City (if applicable) where accident occurred Street or H	ighway	Nearest Cross S	treet	Milepost No.



Vehicle Collision Form

Please type or print in ink

	Year	Make	Model		License Plat	e No.	Location of Car	(where ca	an it be s	een?)			
	Name of Vehicle Owner			Phone - Cell			Phone - Home		Phone - Work				
	Vehicle Owner Address			City				State Zip					
/ehicle #	Name of Driver			Phone - Cell			Phone - Home		Phone - Work				
Your Vehicle Information - Vehicle #1	Driver Address			City				State Zip					
nicle Info	Driver's License Number		State of Issuance		Expir	Expiration Date E		ted \$ Am	ount of Damage				
Your Veh	Your Insurance Company				Phone Nu	ımber		Policy	y Number				
	Describe Da	mage											
	Year	Make	Model		License Plat	e No.	State Agency (if	known)					
	Name of Vel	nicle Owner					Phone - Cell		Phone	- Work			
#2													
	Vehicle Own	er Address				City			State	Zip			
Other Vehicle Information - Vehicle	Name of Dri	ver		Phone	e - Cell		Phone - Home		Phone	- Work			
cle Inforr	Driver Addre	ess				City			State	Zip			
ther Veh	Describe Da	mage (including estim	ated \$)										
0													

Vehicle Collision Form

Please type or print in ink

	Was other (non-vehicle) property damaged? If so, describe what type of property was damaged.									
ıge	Name of Owner	Phone - Cell		Phone - Home	Phone - Work					
Other Property Damage	Owner Address			City		State Zip				
Other Pro	Describe Damage (including	estimated \$)								
	Name	Address	Pł	none	Injury	Age				
	Vehicle 1	Vehicle 2	Vehicle 3		Pedestrian	Other				
	Name	Address	Pł	none	Injury	Age				
ties										
Injured Parties	Vehicle 1	Vehicle 2	Vehicle 3		Pedestrian	Other				
	Name	Address	Pł	none	Injury	Age				
⊑`										
	Vehicle 1	Vehicle 2	Vehicle 3		Pedestrian	Other				
	Name	Address	Pr	none	Injury	Age				
	Vehicle 1	Vehicle 2	Vehicle 3		Pedestrian	Other				
	Witness Name		Phone - Cell		Phone - Home	Phone - Work				
	Witness Address			City		State Zip				
	Witness Name		Phone - Cell		Phone - Home	Phone - Work				
Witnesses										
Vitne	Witness Address			City		State Zip				
>										
	Witness Name		Phone - Cell		Phone - Home	Phone - Work				
	Witness Address			City		State Zip				



Vehicle Collision Form

Please type or print in ink

☐ Straight Road	☐ Hillcrest		naged Areas R
□ Curve – R or L □ Level	□ Uphill □ Downhill	☐ One and One-Half Lane ☐ Two Lane or Four Lane	
Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each. Sidewalk Street Center Sidewalk 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.	VEH. VEH.
Comments			
This information is being provi			on that the foregoing is true and
correct.	jury under the laws (oj the State oj Washingto	on that the foregoing is true and
Claimant - Print Name		Residential Address (stre	eet, city, state, zip)
Claimant's Signature		Date Signed	_



Form: Tort Claim Packet

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.

if you have, or have ever had, a similar Medicar	re card.		IS ENT		(PART A				
Section I			SIGN HERE	DICAL →	(PART E	3) 01-01	-2007		
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	availab	le.)							
Medicare Claim Number: Date of	Birth: (r	nm/da	//уууу)						
Social Security Number: If Medicare Claim Number is Unavailable)	- [Sex	: 🗌	Fem	ale		Male
Section II									
I understand that the information requested is to assist the requesting insurance arran	ngement	t to acc	curately	/ coo	rdina	te be	enefit	ts w	ith
Medicare and to meet its mandatory reporting obligations under Medicare law.									
Claimant Name (Please Print)	_		Claim	n Nur	nber				
· · · · · · · · · · · · · · · · · · ·									
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 t proceed to Section III.	the infor	rmatio	n reque	sted	in Se	ction	s I ar	nd II,	•
Section III									
Claimant Name (Please Print)	_		Claim	. Niur	mhor				
						c.			
For the reason(s) listed below, I have not provided the information requested. I unders not provide the requested information, I may be violating obligations as a beneficiary t							-		
my claims correctly and promptly.									
Reason(s) for Refusal to Provide Requested Information:									

Date

Signature of Person Completing this Form