TORT CLAIM FORM PACKET

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

Documents Contained in the Tort Claim Form Packet

- Instructions for completing the Tort Claim Form
- Tort Claim Form
- Medical Authorization

Legal Requirements for Presenting Tort Claim Forms

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

- Claimant; or
- Person holding a written power of attorney from the Claimant; or
- Attorney admitted to practice in Washington State on the Claimant's behalf; or
- Court-approved guardian or guardian ad litem on behalf of the Claimant.

Present in Person or Mail the Tort Claim Form and Supporting Documents to:

Bridgette Scott, Executive Assistant ***or***
Nick Kooiker, CFO/Auditor
Port of Kennewick
350 Clover Island Drive, Suite 200
Kennewick, WA 99336

A claim is deemed presented when the claim form is delivered in person or is received by the agent by regular mail, registered mail or certified mail with return receipt requested, to the agent(s) designated above.

Instructions for Completing the Tort Claim Form

Please read these instructions carefully before presenting a Tort Claim Form.

- Type or print clearly in ink and sign the Tort Claim Form.
- If the requested information cannot be supplied in the space provided, please use additional pages to complete the Tort Claim Form.
- If you are presenting a personal injury claim, please sign and attach the Medical Release form.
- If the incident that caused the damages occurred over a period of time, please provide the beginning and ending date.
- 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 repairs, wage loss information, and other documentation as appropriate.
- An adjuster will be assigned to your claim after it is submitted. It is to your advantage to present with your claim all relevant supporting documents. All documents may be subject to Washington State Public Disclosure statutes.
- Additional claim forms can be downloaded from the Port of Kennewick website.

TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against the Port of Kennewick. 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 (via email or fax).

Mail or deliver original form to:

Bridgette Scott, Executive Assistant ***or***
Nick Kooiker, CFO/Auditor
Port of Kennewick
350 Clover Island Drive, Suite 200
Kennewick, WA 99336

Business hours: Monday through Friday 8:00 a.m. to 4:30 p.m. Closed on weekends and holidays

CLAIMANT INFORMATION

Claimant's Name: _____
Last First Middle

Date of Birth: _____

Current Residential Address: _____

Mailing Address (if different): _____

Residential Address at Time of Incident: _____

Telephone number(s): _____ _____
Home/Cell Business

Email address: _____

INCIDENT INFORMATION

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Description of the conduct or circumstances that brought about the injury or damage:

Description of injury and/or damage:

Names, addresses and telephone numbers of all persons involved in or witness to this incident and of all Port of Kennewick employees having knowledge of this incident:

Names, addresses and telephone numbers of all individuals not already identified that have knowledge regarding the liability issues involved in this incident or knowledge of claimant's damages. Please include a brief description of the nature and extent of each individual's knowledge.

Was this incident reported to law enforcement, Port of Kennewick or other personnel? If so, when and to whom. Please include the Police department case number and/or copy of the report.

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

Name, address and telephone number of your employer if claiming lost wages. Please identify your position and rate of pay.

Amount of damages claimed: $ _____

Please attach all documents which support the allegations and claimed damages.

This Tort 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.

_____ _____

Date Signature

Authorization for Release of Protected Health Information

Full Name: _____

Date of Birth: _____

Social Security No.: _____

Medicare/Medicaid Recipient: Yes _____No _____

I hereby authorize disclosure of my protected health information for the purpose of processing my claim for damages filed with the Port of Kennewick. Please send legible copies of all records to:

Bridgette Scott, Port Executive Assistant
Port of Kennewick
350 Clover Island Drive, Suite 200
Kennewick, WA 99336

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 information related to HIV testing and/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 and/or treatment records. Pharmacy prescriptions and reports.

All correspondence and documents 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 programs(s) and agency: _____

Financial records related to my care and treatment.

I understand the following: (PLEASE READ AND **INITIAL** ALL STATEMENTS)

_____ My records are protected under HIPAA/PHI regulations (federal law) and the Washington State Health Care Information Act (RCW 70.02).

_____ My health information may be subject to re-disclosure by the Port of Kennewick and not protected for purposes of evaluating and investigating the claim I have filed.

_____ The specific information to be disclosed in my medical record may include information relating to alcohol, drug or other controlled substance use, counseling referrals and/or a history of testing or treatment of HIV/AIDS.

_____ I may revoke this Authorization at any time by notifying the Port of Kennewick in writing. The revocation will be effective as of the date the Port of Kennewick receives it. Any records obtained pursuant to this Authorization prior to the revocation will be deemed authorized by me for release.

_____ This Authorization will expire ninety (90) days from the date I sign it. I can also authorize a different time frame for this release to be valid.

A copy of this Authorization is as valid as the original.

Date: _____ _____

(Signature)

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 other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 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.

We are asking you to the 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 your 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 _____