Standard Tort Claim Form Packet
(Island County)

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

Engrossed Substitute House Bill 1553, effective July 26, 2009, requires citizens to present the Standard Tort Claim Form with the Island County Risk Manager. Island County is required to make available the Standard Tort Claim Form with instructions on how the form is to be presented and provide the identity, address and business hours of the Island County Risk Manager. This packet contains that form and information.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Authorization for Release of Protected Health Information (PHI)
4. Vehicle Collision Form only for tort claims involving vehicle accidents/collisions

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:

Island County
Risk Management Division
Island County Administration Bldg., Room 200
1 NE Seventh St.
PO Box 5000
Coupeville, WA 98239

Business Hours: Monday-Friday, 8:00 a.m. to 4:30 p.m.
Closed on weekends and official county 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 other 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. Smith, Karen Michelle
  2. 1234 College Way NW, Apt. 56, Seattle, WA 98178
  3. PO Box 910, Seattle WA 98178
  4. Same (or residence at the time of incident)
  5. 206-123-4567
  6. ksmith@verizon.net
  7. 08/09/2008, 8:00 a.m.
  8. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 8.
  9. Washington, Island, no city, on county road.
  10. Patmore Rd. Eastbound, near the intersection with Keystone Road.
  11. Island County Public Works, Road Division.
  12. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle, WA 98178 (360) 456-3456; Tow Truck Driver, Simmons Towing
  13. 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 of the person you spoke with.
  17. 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 records and bills.
  18. Attach any other documents that support your claim.
  19. 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 Authorization for Release of Protected Health Information (PHI) form.

  - If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

STANDARD TORT CLAIM FORM
(Island County)

For Official Use Only
No.

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Island County, its officers, employees or volunteers. Some of the information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure. Pursuant to the current law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to

Island County
Risk Management Division
Island County Administration Bldg., Room 200
1 NE 7th St.
PO Box 5000
Coupeville, WA 98239

Business Hours: Mon. – Fri., 8:00 a.m. – 4:30 p.m.
Closed on weekends and official county holidays.

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 at the time of the incident (if different from current address):

_____

5. Claimant's daytime phone number: _____ _____
Home Business

6. Claimant's email address: _____

INCIDENT INFORMATION

7. Date of the incident: _____ Time: _____ ☐ a.m. ☐ p.m. (check one)
(mm/dd/yyyy)

8. If the incident occurred over a period of time, date of first and last occurrences:
from _____ Time: _____ ☐ a.m. ☐ p.m. (check one) to _____, Time: _____ ☐ a.m. ☐ p.m. (check one)
(mm/dd/yyyy) (mm/dd/yyyy)

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 intersecting street

11. County agency or department alleged responsible for damage/injury:

_____

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

_____

_____

_____

13. Names, addresses and telephone numbers of all County employees, officers, or volunteers having knowledge of this incident:

14. Names, addresses and telephone numbers of all individuals not already identified in #12 and #13 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.

15. 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.

16. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

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

18. Please attach documents which support the allegations of this claim.

19. I claim damages from Island County in the sum of $_____.

This 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)***

Claim# _____

Authorization for Release of Protected Health Information (PHI) to Island County Risk Management Division

Name: _____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day ____ Year _____

I hereby authorize disclosure of my protected health information to Island County, Risk Management Division, for purposes of processing my claim for damages filed with Island County.

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; 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 Island County and not protected for purposes of evaluating and investigating the claim I have filed with Island County.

_____ 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 Island County in writing, and that the revocation will be effective as of the date Island County 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 Island County.

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

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:

Island County
Risk Management Division
Island County Administration Building, Room 200
1 NE 7th St.
P.O. Box 5000
Coupeville, WA 98239

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.

CLAIMANT'S NAME **(A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)**	DATE OF ACCIDENT(mm/dd/yyyy)	TIME AM PM

CURRENT STREET (RESIDENCE) ADDRESS	CITY	STATE	ZIP	PHONE HOME WORK
(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT	CITY	STATE	ZIP	EMAIL

State//County/City (if applicable) where occurred	STREET OR HWY	MILEPOST NO.	INTERSECTION OR NEAREST STREET/ROAD

YEAR	MAKE	MODEL	LICENSE PLATE NO.	W HERE CAN CAR BE SEEN?	W HEN?

NAME OF VEHICLE OWNER	ADDRESS	CITY	HOME AND WORK PHONE
NAME OF DRIVER	ADDRESS	CITY	HOME AND WORK PHONE

DRIVER'S LICENSE NUMBER	STATE OF ISSUANCE	DATE OF EXPIRATION

DESCRIBE DAMAGE	ESTIMATE $	YOUR INSURANCE COMPANY AND POLICY NO.

YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOW N

NAME OF OW NER	ADDRESS	CITY	PHONE
NAME OF DRIVER	ADDRESS	CITY	PHONE

DESCRIBE DAMAGE	ESTIMATE $

WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.

NAME OF OWNER	**ADDRESS**	**CITY**	**PHONE**

DESCRIBE DAMAGE	ESTIMATE $

NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
		HOME WORK							
		HOME WORK							
		HOME WORK							
		HOME WORK							
		HOME WORK							

NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)	ADDRESS	CITY	PHONE
			HOME WORK
			HOME WORK
			HOME WORK

COMPLETE ALL DETAILS

Describe 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.

_____

_____

_____

_____

_____

_____

Straight Road
Curve – R or L
Level

Hillcrest
Uphill
Downhill

One Lane
One and One-Half Lane
Two Lane or Four Lane

LIGHT CONDITIONS (CHECK ONE)	TRAFFIC CONTROL	TYPE OF ROAD (CHECK ONE OR MORE)	VEHICLE CONDITION (CHECK ONE OR MORE)	ROAD SURFACE (CHECK ONE)	WEATHER (CHECK ONE)
1 DAYLIGHT	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	1 CLEAR, CLOUDY & OVERCAST
2 DAWN	1 SIGNALS	1 ONE WAY	1 DEFECTIVE BRAKES	1 DRY	2 RAINING
3 DUSK	2 STOP SIGN	2 TWO WAY	2 DEFECTIVE HEADLIGHTS	2 WET	3 SNOWING
4 DARK STREET LIGHTS ON	3 RED	3 REVERSIBLE ROAD	3 DEFECTIVE REAR LIGHTS	3 SNOW	4 FOG
5 DARK STREET LIGHTS OFF	4 AMBER	4 INTER-CHANGE LOOP RAMP	4 TIRES WORN	4 ICE	5 OTHER (SPECIFY)
6 DARK NO STREET LIGHT	5 RR SIGNAL	5 ALLEY	5 PUNCTURED OR BLOWN TIRES	5 OTHER (SPECIFY)	
7 OTHER (SPECIFY)	☐ OFFICER/ FLAGMAN	6 TWO WAY-LEFT TURN LANES	6 OTHER (SPECIFY)		
	7 YIELD SIGN	1 SEPARATED		NAME OF INVESTIGATING POLICE AGENCY: _____	
	8 ☐ NO CONTROL	2 DIVIDED		INVESTIGATING AGENCY REPORT NO. _____	
	9 OTHER	3 UNDIVIDED			