Standard Tort Claim Form Packet

Please *carefully read all of the information in this packet* before completing and submitting your Standard Tort Claim. Please note that no documents will be returned.

Presenting a Standard Tort Claim Form

RCW 4.92.100 requires individuals to present the Standard Tort Claim form with the Office of Risk Management (ORM). The law also requires ORM to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of individuals, ORM developed a Standard Tort Claim Form Packet.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form (SF 210)
3. Medical Authorization (only for tort claims involving bodily injury)
4. Vehicle Collision Form (only 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

Submit the Standard Tort Claim Form and Supporting Documents by mail or in person to:

Steilacoom Historical School District
Superintendent Office
511 Chambers Street
Steilacoom, WA 98388

For business hours call 253-983-2200 or email
info@steilacoom.k12.wa.us

INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM

General Liability Claim Form #SF 210

- ✓ 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 in claim form in binders or add divider tabs as all documents must be scanned.
- ✓ 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 claim can be easily read and understood.

- ✓ The following are *examples* on how to complete the Tort Claim Form #SF 210:

1) Smith, Karen Michelle – 02/20/1965
2) #809234 (for use by Department of Corrections inmates only)
3) 1234 Bowzer Way NW, Apt. 56, Floville WA 99561
4) PO Box 910, Seattle WA 92569
5) Same (or residence at the time of incident)
6) Claimant's phone number(s) w/ area code
7) Claimant's or Representative's email address
8) 8/9/2020 8:00 a.m.,
9) 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.
10) Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22.
11) I-5, Southbound, Milepost 109, near the Martin Way Exit
12) Washington State Department of Transportation
13) Smith, John Doe, 1234 Blank Way NW, Apt. 56, Biddle, WA 93215 (360) 456-XXXX; Tow Truck Driver, Nisqually Towing
14) List any state employees who have knowledge about 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. 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.
16) Please describe the incident that resulted in the 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 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.
19) Please attach any additional documents that support your claim.
20) 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.
- ✓ If your claim involves a motor vehicle accident, please complete, sign, and attach the vehicle accident form.

For Official Use Only

STANDARD TORT CLAIM FORM

General Liability Claim Form #SF 210

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the state of Washington. Some of the information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure.

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to

Steilacoom Historical School District
Superintendent Office
511 Chambers Street
Steilacoom, WA 98388

Business Hours: contact 253-983-2200 or email info@steilacoom.k12.wa.us

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 the time of the incident: _____
   (if different from current address)
6. Claimant's daytime telephone number: _____ _____
   Home Business or Cell
7. Claimant's e-mail address: _____
8. Date of the incident: _____ Time:_____ ☐ a.m. ☐ p.m. (check one)
   (mm/dd/yyyy)
9. If the incident occurred over a period of time, date of first and last occurrences:

   from _____ Time: _____ ☐ a.m. ☐ p.m.
   (mm/dd/yyyy) (mm/dd/yyyy)

   to _____ Time:_____ ☐ a.m. ☐ p.m.
   (mm/dd/yyyy) (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. State agency or department alleged responsible for damage/injury:

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

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

15. 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.

16. 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.

17. 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.

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

19. Please attach documents which support the allegations of the claim.

20. I claim damages from the state of Washington 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)***
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
Steilacoom Historical School 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 Steilacoom Historical School District for purposes of processing and evaluating 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 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)**

_____ 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 SHSD and not protected for purposes of evaluating and investigating the claim I have filed with the school district.

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

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

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:

Steilacoom Historical School District
Attn: Tort Claim Records
511 Chambers Street
Steilacoom, WA 98388