Presentment and Filing of Tortious Claims Against the Hospital District

Administration

Type: Policy
Status: Official
Last Reviewed: 6/9/2021

Policy

In accordance with RCW 4.96.020, all claims for damages against Public Hospital District No. 1, Kittitas County, dba Kittitas Valley Healthcare (KVH), shall be presented to and filed with the Board of Commissioners within the applicable period of limitations for which an action must be commenced. Filing with the Board of Commissioners may be accomplished by personal delivery of a claim to the Board of Commissioners' designated agent who is the Chief Executive Officer (CEO) in the administrative offices of Kittitas Valley Healthcare, or in his/her absence the Risk Manager, located at 603 South Chestnut, Ellensburg, Washington 98926. The claim must be signed and dated by the claimant.

Procedure

All claims for damages arising out of tortious conduct must locate and describe the conduct and circumstances which brought about the injury or damage, describe the injury or damage, state the time and place the injury or damage occurred, state the names of all persons involved, if known, and shall contain the amount of damages claimed, together with a statement of the actual residence of the claimant at the time of presenting and filing the claim, and for a period of six months immediately prior to the time the claim arose.

Claim forms are available from the administrative offices of Kittitas Valley Healthcare at 603 South Chestnut, Ellensburg, Washington, outlining the information required to be submitted with the claim.

The claim will be stamped with the "Date Received" and initialed when received in the administrative offices.

If the claimant is incapacitated and therefore prevented from verifying, presenting and filing the claim in the time prescribed, or if the claimant is a minor, or if the claimant is a non-resident of the state absent during the time within which the claim was required to be filed, the claim may be verified, presented and filed on behalf of the claimant by any relative, attorney, or agent representing the claimant.

Effective Date:	05/30/2007	**Document Owner:**	CEO	**Review Date(s):**	6/9/2021; 2/6/2020; 7/20/2023
				Revision Date(s):	8/26/2014; 8/28/15; 1/7/16; 5/22/17; 10/24/2018

Print Date: 7/25/2023

Standard Tort Claim Form Packet

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

- 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; and,
  - Receipts for property value.
- If the requested information cannot be supplied in the space provided, please use additional blank sheets so that your Standard Tort Claim form can be easily read and understood.

Documents contained in Kittitas Valley Healthcare Hospital's Standard Tort Claim Packet are:

1. Kittitas Valley Healthcare Hospital's Standard Tort Claim Form.

2. A Vehicle Collision Form only for tort claims involving vehicle accidents/collisions.

Legal requirements for presenting Standard Tort Claims Forms:

- In order to verify the claim and additional supporting information, the law requires that Kittitas Valley Healthcare Hospital's 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:

  Administration Office
  Kittitas Valley Healthcare, 603 S. Chestnut, Ellensburg, WA 98926
  Business Hours: 8:00 a.m. – 4:30 p.m.

Closed on weekends and holidays

Claim Form for Tortious Conduct of Local Government Entity

This claim must be completed by all parties alleging a claim for damages resulting from the tortious conduct of Kittitas Valley Healthcare.

In accordance with RCW 4.96.020, all claims for damages against Kittitas Valley Healthcare shall be presented to and filed with the Public Hospital District's designated agent, the Chief Executive Officer (CEO), or in his/her absence the Risk Manager, at 603 South Chestnut, Ellensburg, Washington 98926 within the applicable period of limitations within which an action must be commenced.

Standard Tort Claim Form

General Liability Claim Form

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

PLEASE TYPE OR PRINT IN

For Official Use only

No.

Mail or deliver original claim to:
Chief Executive Officer
or Risk Manager
603 S. Chestnut St., Ellensburg, WA 98926

Business Hours are .8:00 a.m. - 4:30 p.m.
Monday - Friday

CLAIMANT INFORMATION:

1. Claimants 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 telephone number: Home:_____-_____-_____Business: _____-_____-_____

6. Claimant's e-mail address: _____

INCIDENT INFORMATION:

7. Date of the incident: ____/____/_____ (mm/dd/yyyy) Time: _____ (circle one) AM PM

8. If the incident occurred over a period of time, date of first and last occurrences: from ___/___/_____ Time: ____ (circle one) AM PM to___/___/_____ Time ____ (circle one) AM PM

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

_____ ____-____-_____ _____ ____-____-_____
Name Number Name Number

_____ ____-____-_____ _____ ____-____-_____
Name Number Name Number

_____ ____-____-_____ _____ ____-____-_____
Name Number Name Number

12. Names, addresses and telephone numbers of Hospital employees having knowledge of this incident.

13. Names address and telephone numbers of all individuals not already identified in #11 and #12 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.

14. 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.

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

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

17. Please attach documents which support the claim's allegations.

18. I claim damages from Kittitas Valley Healthcare in the sum of $_____.

This Standard 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 the State of Washington on the Claimant's behalf, or by a court-appointed 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)

Authorization for Release of Protected Health Information (PHI) to Kittitas Valley Healthcare, Office of Risk Management

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 Department of Enterprise Services, Office of Risk Management (Risk Management) 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 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)**

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

_____ I understand that my health information may be subject to re-disclosure by Risk Management and not protected for purposes of evaluating and investigating the claim I have filed with the state of Washington.

_____ 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.

_____ I understand that I may revoke this authorization at any time by notifying Risk Management in writing, and that the revocation will be effective as of the date Risk Management 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.

_____ 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 RMD.

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

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

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.

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 (mmddyyyy)**	
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**