

**INSTRUCTIONS FOR COMPLETING
The JEFFERSON COUNTY CLAIM FOR DAMAGE FORM**

Before presenting a Jefferson County Claim for Damages Form please read these instructions and the Claim for Damages Form in its entirety.

Type or print clearly in ink and sign the Claim for Damages Form. The Jefferson County Claim for Damages Form must 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

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 understood.

The following are examples on how to complete the numbered items on the Claim for Damage form:

- 1) Smith, John Conner, 12/01/1910
- 2) 222 One Way Street, Apt. Z, Port Townsend, WA 98368
- 3) Post Office Box 101, Quilcene, WA 98376
- 4) 360-123-4567 360-123-4567 360-123-4567
- 5) 222 One Way Street, Apt. Z, Port Townsend, WA 99201
- 6) claimant1@comcast.net
- 7) 01/01/2009, 8:00 a.m.
- 8) From: October 31, 2009 8:00 p.m. To: November 2, 2009 7:00 a.m.
- 9) Washington, Jefferson; Chimacum County maintained road.
- 10) Center Road northbound, milepost 4.0 Egg & I Road
- 11) Please describe the incident that resulted in the injury, or damages, specifically answering the questions who, what, where, when and why.
- 12) Jefferson County Roads Department
Smith, Jenny, 222 One Way Street, Apt. Z, Port Townsend, WA 98368, (360)123-4567, riding
- 13) in the car at the time of the incident; Fitzgerald, Who sits, 3287 Wonderful Lane, Brinnon, WA 98331, (360)111-1111; witnessed the incident.
- 14) List address and telephone numbers of all County Departments and employees having knowledge about this incident.

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
- 15) a description of their knowledge. For example, if your sister was with you, when the alleged incident occurred, please include her name, address, and telephone number, and indicate she witnessed the incident.

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16) Describe how the damages or injury was caused.

17) If you reported this incident to law enforcement, safety or security personnel, please provide the name of the person you spoke with, and the date and time you spoke to them and include a copy of the report or contact information for the person with whom you spoke.

18) Please provide a list of all your medical providers, including their names, address, telephone numbers, and the type of treatment. Please attach copies of all medical records and billings if you were treated for a personal injury under this claim.

19) Attach documents which support the claim's allegations.

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 damages.

21) If you were injured, please indicate if you are Medicare eligible and provide your Medicare number. If you are presenting a personal injury claim, submit the Medical Release form.

22) Please provide the name of the company that provides you insurance for this type of claim.

23) If your claim involves vehicle accident, submit the Vehicle Collision Form

JEFFERSON COUNTY Claim for Damages

This Claim Form is provided solely as an accommodation to claimants, and the County makes no representations as to its legal sufficiency. Responsibility for complying with all requirements of State law regarding claims rests with the claimant. No County Employee is authorized to advise a claimant in completing this form or reviewing its sufficiency. The County expressly disclaims responsibility for any such advice or review. Information requested on this form may be subject to public disclosure. This claims form **must be presented with an original signature** and cannot be submitted electronically (by e-mail or fax.)

PLEASE TYPE OR PRINT IN INK

Mail or Deliver
Original claim to:

RISK MANAGER
JEFFERSON COUNTY COURTHOUSE
1820 JEFFERSON STREET
PO BOX 1220
PORT TOWNSEND, WA 98368

Business Hours:
Mon. - Fri. 8:30 a.m. to 4:30 p.m.
Closed on weekends and officials
State and Federal Holidays

CLAIMANT INFORMATION

I, AS THE CLAIMANT, HEREIN BELIEVE THE CONTENTS OF THIS CLAIM TO BE TRUE. I HEREBY PRESENT A CLAIM FOR DAMAGES AGAINST JEFFERSON COUNTY, WASHINGTON, BASED UPON THE FOLLOWING INFORMATION AS REQUIRED BY RCW 4.96.020 AND 36.45.010:

If more space is needed to answer any items, attach additional sheet and specify the item number.

My name, address and phone number **at the time of presenting and filing this claim** is:

1) Name _____ Date of Birth: _____
(Last) (First) Middle (mm/dd/yy)

2) Physical Residence Address: _____

3) Mailing Address (if different than residence): _____

4) Daytime Phone Numbers: _____
(Home) (Business) (Cell)

5) Physical Residential address for six (6) months immediately prior to the date of the incident (if different from current address):

6) Your e-mail address: _____

INCIDENT INFORMATION

7) Date Incident Occurred: _____ Time: _____ A.M. or P.M.
(mm/dd/yyyy)

8) If the incident occurred over a period of time, date of first and last occurrences:
FROM: _____ Time: _____ A.M. or P.M. **TO:** _____ Time: _____ A.M. or P.M.

9) Location of incident: _____
(State & County) (City, if applicable) (Place where occurred)

10) If the incident occurred on a street or highway: _____
(Name of street/highway) (Milepost)

(at intersection with or nearest intersecting street)

11) The nature of the damages or injury I sustained are: _____

12) Jefferson County Department(s) or employee(s) allegedly responsible for damage/injury: _____

13) Name(s) address, and telephone number(s) of all persons involved in, or witness to, this incident: _____

14) Name(s), address, and telephone number(s) of all Jefferson County department(s) or employee(s) having knowledge of this incident: _____

15) Name(s), address, and telephone number(s) 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.

16) Describe the cause of the damages or injury. Explain the extent of property loss or medical expenses. _____

17) Has the incident been reported to law enforcement, safety or security personnel? If so, when was it reported and to whom?:

18) Provide name(s) addresses, and telephone number(s) of treating medical providers. Attach copies of all medical reports and billings:

19) Please attach all documents which support your claim:

20) I claim damages from Jeffrson County in the sum of \$ _____
The amount of damages sustained must be itemized

21) If you are injured, are you a Medicare beneficiary? Yes No
If Yes, please provide your Medicare # _____

22) The name of my insurance agency is: _____

23) If your claim involves a motor vehicle accident, complete, sign and include the attached vehicle collision form. Two (2) estimates of the cost of repairs must be attached to this claim with the amount of damages sustained itemized.

24) If you are presenting a personal injury claim, complete, sign and include the attached Medical Release form

This claim form must be signed by the Claimant, a person holding a written power of attorney from the Claimant to serve as 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 _____

Place (residential address) _____

Print Name _____

Place (City & County) _____

Title (if Claimant is a Company) _____

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 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please complete the following. If no, proceed to Section II.</i>			
Full Name: <i>(Please print the name exactly as it appears on your SSN or Medicare card if available.)</i>			
Medicare Claim Number:		Date of Birth (Mo/Day/Year)	
Social Security Number: <i>(If Medicare Claim Number is Unavailable)</i>		Sex	<input type="checkbox"/> Female <input type="checkbox"/> 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

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I, _____ (print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

(X) Insurance Company () Workers' Compensation Carrier () Other _____
(Explain)

Name of entity: Washington Counties Risk Pool

Contact for above entity: Tammy Cahill

Address: 2558 R.W. Johnson Road SW #106
 Tumwater, WA 98512

Telephone: 360-292-4484

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below.):

() One Year () Two Years () Other _____
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date signed: _____

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit www.msprc.info for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card.): _____

Date of Injury/Illness: _____