

# Standard Tort Claim Form Packet

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 to the City of Prosser. The law also requires the City to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, the City 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
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:

City of Prosser  
601 7<sup>th</sup> Street  
Prosser, Wa 99350

Business Hours: Monday-Friday, 8:00 a.m. to 5:30 p.m.  
Closed on weekends and official state 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 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 , 2/28/1944
  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@emailaddress.com
  7. August 9, 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 7
  9. Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building Number 22
  10. I-5, Southbound, Milepost 109, near the Martin Way Exit
  11. Washington State Department of Transportation, Highway
  12. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually 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 for the person you spoke with.
  17. Please provide all contact information on 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 all supporting documents.
  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 Medical Release form.
- If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.



from \_\_\_\_\_ Time: \_\_\_\_\_ a.m./ p.m. (*circle one*)  
to \_\_\_\_\_, Time: \_\_\_\_\_ a.m./ p.m. (*circle one*) (*mm/dd/yyyy*)



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

---

---

---

**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 claim's allegations.

**20.** I claim damages from the City of Prosser 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***

---

***Place (residential address, city and county)***

**Authorization for Release of Protected Health Information (PHI)  
to  
The City of Prosser, WA**

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 City of Prosser for purposes of processing my claim for damages filed with the City of Prosser.

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)**

\_\_\_\_\_ 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 the City of Prosser not protected for purposes of evaluating and investigating the claim I have filed with the City of Prosser.

\_\_\_\_\_ 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 the City of Prosser in writing, and that the revocation will be effective as of the date City of Prosser 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 the City of Prosser.

---

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

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:

The City of Prosser  
601 7<sup>th</sup> Street  
Prosser, Wa 99350