

STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the LOTT Alliance. 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 new 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 LOTT Alliance
Attn: Erin Michael
Administrative Services Manager
111 Market St. NE, Ste. 250
Olympia, WA 98501

Business Hours: Mon. – Fri. 8:00 a.m. – 4:30 p.m.
Closed on weekends and observed 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 telephone number _____
Home Business
6. Claimant's e-mail 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)
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. State 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 employees having knowledge about 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 of 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 claim's allegations.
19. I claim damages from the LOTT Alliance 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
The LOTT Alliance (LOTT)

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 LOTT Alliance, for purposes of processing my claim for damages filed with the LOTT Alliance.

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 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 LOTT and not protected for purposes of evaluating and investigating the claim I have filed with LOTT Alliance.

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

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

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:

Erin Michael
Administrative Services Manager
LOTT Alliance
111 Market St. NE, Suite 250
Olympia, WA 98501

CLAIM FOR DAMAGES FORM

Date Claim Form Received by Member _____
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MEMBER CITY/ORGANIZATION: _____

Please take note that _____, who currently resides at _____
_____, mailing address _____
_____, home phone # _____, work phone # _____, and who resided at _____
_____ at the time of the occurrence and whose date of birth is _____ is claiming damages
against _____ in the sum of \$ _____ arising out of the following circumstances listed below.

DATE OF OCCURRENCE: _____ **TIME:** _____

LOCATION OF OCCURRENCE: _____

DESCRIPTION:

1. Describe the conduct and circumstance that brought about the injury or damage. Also describe the injury or damage

~~~~~ (attach an extra sheet for additional information, if needed)

2. Provide a list of witnesses, if applicable, to the occurrence including names, addresses, and phone numbers.

3. Attach copies of all documentation relating to expenses, injuries, losses, and/or estimates for repair.

4. Have you submitted a claim for damages to your insurance company? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please provide the name of the insurance company: \_\_\_\_\_

and the policy #: \_\_\_\_\_

**\*\* ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY \*\***

License Plate # \_\_\_\_\_ Driver License # \_\_\_\_\_

Type Auto: \_\_\_\_\_

(year) (make) (model)

**DRIVER:** \_\_\_\_\_ **OWNER:** \_\_\_\_\_

|                         |                         |
|-------------------------|-------------------------|
| Address: _____<br>_____ | Address: _____<br>_____ |
| Phone#: _____           | Phone#: _____           |
| <b>Passengers:</b>      |                         |
| Name: _____             | Name: _____             |
| Address: _____<br>_____ | Address: _____<br>_____ |

\* \* NOTE: THIS FORM MUST BE SIGNED AND NOTARIZED \* \*

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the claimant for the above described; that I have read the above claim, know the contents thereof and believe the same to be true.

X \_\_\_\_\_

X \_\_\_\_\_

Signature of Claimant(s)

State of Washington

County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_ is the person who appeared before me, and said person acknowledged that (he/she) signed this instrument and acknowledged it to be (his/her) free and voluntary act for the uses and purposes mentioned in the instrument.

Dated: \_\_\_\_\_

\_\_\_\_\_

Signature

\_\_\_\_\_

Title

My appointment expires \_\_\_\_\_