Post Office Box 878
Ephrata, Washington 98823
(509) 754-5088 ● FAX: (509) 754 -5012
www.grantpud.org

STANDARD TORT CLAIM FORM PACKET

Please *carefully read all of the information in this packet* before completing and presenting your tort claim.

DOCUMENTS CONTAINED IN THE STANDARD TORT CLAIM FORM PACKET:

- Instructions for completing the Tort Claim Form
- Standard Tort Claim Form
- Medical Authorization Form (only for claims involving personal injury)
- Vehicle Collision Form (only for claims involving a vehicle accident/collision)

LEGAL REQUIREMENTS FOR PRESENTING TORT CLAIM FORMS:

In order to verify the claim and supporting information, the law requires that the Tort Claim Form be signed by:

- Claimant; or
- Person holding a written power of attorney from the Claimant; or
- Attorney admitted to practice in Washington State on the Claimant's behalf; or
- Court-approved guardian or guardian ad litem on behalf of the Claimant.

PRESENT IN PERSON OR MAIL THE TORT CLAIM FORM AND SUPPORTING DOCUMENTS TO:

Public Utility District No. 2
Of Grant County
Risk Management
30 C Street SW
Post Office Box 878
Ephrata, WA 98823

Attention: Risk Analyst (Agent)
or; Chief Financial Officer (Deputy Agent) or;
Assistant General Manager (Deputy Agent)

Business hours: Monday through Friday from 8:00 a.m. through 5:00 p.m. Closed on weekends and official holidays.

A claim is deemed presented when the Claim Form is delivered in person or is received by the Agent for Grant County Public Utility District designated above via regular mail, registered mail, or certified mail with return receipt requested.

INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM

- Before filing a Tort Claim, 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 claim can be easily read and understood.
- **If you are presenting a personal injury claim, please sign and attach the Medical Release form.**
- The following are examples on how to complete the Standard Tort Claim Form:

1. Smith, Sally Marie February 11, 1965
2. 1234 Main Street NW, Apt. 6, Ephrata, WA 98823
3. PO Box 911, Ephrata, WA 98823
4. Same (or residence at the time of incident)
5. (509) 123-4567; (509) 123-4569
6. janedoe@email.com
7. June 1, 2009 8:00 am
8. If the incident that caused the damages occurred over a period of time, please provide the beginning date and time listed in item 7 and the ending time and date.
9. Grant County, Ephrata, private residence
10. Nat Washington Blvd., Westbound, intersection of Nat Washington and A Street SE
11. Smith, Thomas Arthur, 1234 Ridge Way NW, Apt. 2, Moses Lake, WA 98837 (509) 766-0000; Tow Truck Driver, Joe's Towing

    List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers. 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.
12. Describe how the damage or injury occurred, specifically answering the questions who, what, where, when and why.
13. If claiming damaged personal property, list the items, when you purchased each item, their original cost, what repair costs would be, or were, and if surge protection was in use (if an electrical related claim).
14. 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.
15. Please provide information of all your medical providers with their names, addresses, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
16. Attach receipts, pictures, witness statements or any other document to support your claims allegation.
17. Please provide the dollar amount for your damages, including medical costs, property damage loss, etc. This amount should represent your opinion of total compensation.

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STANDARD TORT CLAIM FORM

For Grant PUD Use Only

General Liability Claim Form

Engrossed Substitute House Bill 1553, effective July 26, 2009, requires citizens to present the Standard Tort Claim form for filing a tort claim against Grant County Public Utility District. Information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Claim forms cannot be submitted electronically (via e-mail or fax). A separate Claim form must be filed for each Claimant.

PLEASE TYPE OR PRINT IN INK

Mail or deliver original claim to:

Public Utility District No. 2
Of Grant County
Attn: Risk Analyst, Agent
30 C Street SW
Post Office Box 878
Ephrata, WA 98823

CLAIMANT INFORMATION

1. Claimant's name *(Last, First, Middle):*

2. Date of birth (*mm/dd/yyyy*):

3. Current residential address:

4. Mailing address (if different):

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

6. Claimant's daytime telephone number(s):

(Home)_____ (Work or Cellular) _____

7. Claimant's e-mail address:

INCIDENT INFORMATION

8. Date of the incident:

Time:

a.m. ☐ p.m. ☐ (*check one*)

9. If the incident occurred over a period of time, date of first and last occurrences:

From: _____ (*mm/dd/yyyy*), Time: _____ a.m. ☐ p.m. ☐ To: _____ (*mm/dd/yyyy*) Time: _____ a.m. ☐ p.m. ☐

10. Location of incident:

County; City; Place of occurrence

11. If incident occurred on a street or highway:

Name of street; Street Address or nearest Mile Post; At the intersection with or nearest intersecting street

INCIDENT INFORMATION (continued)

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

13. Describe the cause of the injury or damages.

14. List of Damaged Items**:**

Item	Purchase Date	Purchase Price	Repair Cost Estimate ☐ Actual ☐	Was surge protection in use?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

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

16. (If claiming injuries) Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

17. Please attach and list documents including receipts, pictures, witness statements or any other documents to support the claim's allegations, including Police Incident Report if your claim involves a motor vehicle accident:

18. I claim damages from Grant PUD in the sum of: _____ Dollars; $ _____

SIGNATURE OF CLAIMANT

This claim form must be signed by the Claimant, a person holding a written power of attorney from claimant, an attorney for the Claimant, by an attorney admitted to practice in Washington State of behalf of the Claimant, or by a court-approved guardian or guardian ad litem on behalf of the claimant.

I declare under penalty of perjury und the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant **Date** **Residential address, City and County**

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

If you are presenting a **claim for personal injury**, please sign and attach this release form for protected health information to your Tort Claim Form. A separate form must be submitted for each claimant.

CLAIMANT/PATIENT INFORMATION

1. Claimant's name (*Last, First, Middle*): Date of birth (*mm/dd/yyyy*):

_____ _____

I hereby authorize disclosure of my protected health information to Public Utility District No. 2 of Grant County, WA and/or its agent, for purposes of processing my claim for damages filed with the .

I understand that by signing this document, I authorize the release of the following information as it relates to my claim:

- 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; and
- 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; and
- Alcohol assessment, testing, referral or treatment records; and
- All other chemical dependency assessment of treatment records; and
- Pharmacy prescriptions and reports; and
- 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; and
- Urgent care, outpatient or other clinic visit information; and
- Gynecological and/or obstetrical information; and
- All client records generated for or by governmental programs of which I am a client; and
- Financial records related to my care and treatment.

PLEASE READ AND INITIAL ALL STATEMENTS

_____ **I understand** that my records are protected under HIPPA/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 utility and not protected for purposes of evaluating and investigating the claim I have filed with the utility.

_____ **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 utility in writing, and that the revocation will be effective as of the date the utility receives it. Any records obtained pursuant to this Authorization prior to the revocation will be deemed authorized by me for release.

_____ **I understand** that this Authorization will expire ninety (90) days from the date I sign it; and/or until my claim is resolved or closed by the utility. I may authorize an alternate time frame for this Authorization to be valid.

_____ **I understand** that a copy of this Authorization carries the same authority as the original for the purposes of releasing my records to the utility.

SIGNATURE OF CLAIMANT

This claim form must be signed by the Claimant, a person holding a written power of attorney from claimant, an attorney for the Claimant, by an attorney admitted to practice in Washington State of behalf of the Claimant, or by a court-approved guardian or guardian ad litem on behalf of the claimant. Where the signer is not the subject of the records, written proof must be attached.

_____ _____

Signature of Claimant/Patient **Date** **Contact Information**