



CLARK COUNTY WASHINGTON

HUMAN RESOURCES  
RISK MANAGEMENT

[www.clark.wa.gov](http://www.clark.wa.gov)

1300 Franklin Street  
PO Box 5000  
Vancouver, WA 98666 5000  
564.397.2025

February 1, 2018

TO: Tort Claims against Clark County and/or its employees or volunteers

RE: New Claim Form and Procedures, Effective February 1, 2018

The following form is the form utilized by Clark County. It is identical to the Washington State Risk Management, OFM Tort Claim Notice Claim Form.

The more information you provide, the more accurate we can be in our response. Please remember the investigation process may take some time. You are required to mitigate (minimize) your own losses. You may wish to look to your own insurer first if time is of the essence.

For a Tort Claim Notice to be effective it must be substantially complete and it must be delivered to:

Clark County  
Office of Risk Management  
PO Box 5000  
1300 Franklin St., Suite 560  
Vancouver, WA 98666-5000

We will only accept service of our Tort Claim Notice to the County Risk Management Office. We will **NOT** accept emails, Fax, copies of, or other non-original Tort Claim Notices.

We will **NOT** accept letters from any Attorney or anyone else that does not complete the underlying Tort Claim Form completely. For the initial Tort Claim Notice, your Social Security number is not required; however, there may be occasion where we may need it to complete the processing of the claim and/or settlement.

Should you have any further questions, please contact us at 564-397-2025. Those who need TTY or other accommodations, please refer to the Clark County ADA Web Site.



For other formats, contact  
the Clark County ADA Office

Voice 564.397.2322  
Fax 360.397.6165

Relay 711 or 800.833.6388  
Email [ADA@clark.wa.gov](mailto:ADA@clark.wa.gov)

# Clark County Tort Claim Form Packet

Please *carefully read all of the information in this packet* before completing and presenting your Clark County Tort Claim. Tort claims are subject to public disclosure pursuant to RCW 42.56.

**NOTE:** all documents received by the Office of Risk Management (ORM) become the property of ORM and **will not be returned**. Please keep a copy for your records and do not send original attachments if you may want them returned.

## Presenting a Standard Tort Claim Form

RCW 4.92.100 requires citizens to present the Standard Tort Claim form with the Office of Risk Management (ORM). The law also requires ORM to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, ORM developed the Clark County Tort Claim Form Packet.

## Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Clark County Tort Claim Form
2. Standard Clark County Tort Claim Form (SF 210)
3. Medical Authorization (only for tort claims involving bodily injury)
4. Vehicle Collision Form (only for tort claims involving vehicle accidents/collisions)
5. Mandatory Medicare Beneficiary Reporting Form

## 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 Clark County Tort Claim Form & Supporting Documents to:

Clark County  
Office of Risk Management  
PO Box 5000  
1300 Franklin St.  
Vancouver, WA 98666-5000  
Phone (564) 397-2025

Business Hours: Monday-Friday, 9:00 a.m. to 11:00 A.M. and 1:00 p.m. to 4:00 p.m.  
Closed on weekends and official state holidays.

## INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM

### General Liability Claim Form #SF 210

- ✓ Before filing a Tort Claim, please read these instructions, the Tort Claim form and other appropriate forms in their entirety.
- ✓ Type or print **clearly** in ink and sign the Tort Claim form. **Do not staple or tape documents**. Do not put in claim form in binders or add divider tabs as all documents must be scanned.
- ✓ 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.
- ✓ The following are *examples* on how to complete the Tort Claim Form #SF 210:
  - 1) Smith, Karen Michelle – 02/20/1965
  - 2) #809234 (for use by Department of Corrections inmates only)
  - 3) 1234 College Way NW, Apt. 56, Seattle WA 98178
  - 4) PO Box 910, Seattle WA 98178
  - 5) Same (or residence at the time of incident)
  - 6) (206) 123-4567 – (206) 987-6543
  - 7) KMSmith@hotmail.com
  - 8) 8/9/2010 8:00 a.m.,
  - 9) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 8.
  - 10) Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22.
  - 11) I-5, Southbound, Milepost 109, near the Martin Way Exit
  - 12) Washington State Department of Transportation, Highway
  - 13) Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
  - 14) Unknown
  - 15) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 13 and 14. 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.
  - 16) **Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.**
  - 17) 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.
  - 18) Please provide all of 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.
  - 19) Please attach any additional documents that support your claim.
  - 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 compensation.
- ✓ If you are filing a personal injury claim, please sign and attach the Medical Release.
- ✓ If your claim involves a motor vehicle accident, please complete, sign, and attach the vehicle accident form.

# CLARK COUNTY TORT CLAIM FORM

General Liability Claim Form #SF 210

For Official Use Only

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the state of Washington. Some of the information requested on this form is required by RCW 4.92.100 and is subject to public disclosure pursuant to RCW 42.56.

## PLEASE TYPE OR PRINT CLEARLY IN INK

**Mail or deliver original claim to** Clark County  
Office of Risk Management  
PO Box 5000  
1300 Franklin St.  
Vancouver, WA 98666-5000  
Phone: (564) 397-2025

Business Hours: Monday – Friday 9:00 a.m. to 11:00 a.m. and 1:00 p.m. to 4:00 p.m.  
Closed on weekends and official state holidays.

1. Claimant's name: \_\_\_\_\_  
Last name First Middle Date of birth (mm/dd/yyyy)
2. Inmate DOC number (if applicable): \_\_\_\_\_
3. Current residential address: \_\_\_\_\_
4. Mailing address (if different): \_\_\_\_\_
5. Residential address at the time of the incident: \_\_\_\_\_  
(if different from current address)
6. Claimant's daytime telephone number: \_\_\_\_\_  
Home Business or Cell
7. Claimant's e-mail address: \_\_\_\_\_
8. Date of the incident: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m. (check one)  
(mm/dd/yyyy)
9. If the incident occurred over a period of time, date of first and last occurrences:  
from \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
(mm/dd/yyyy) (mm/dd/yyyy)  
to \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
(mm/dd/yyyy) (mm/dd/yyyy)
10. Location of incident: \_\_\_\_\_  
State and county City, if applicable Place where occurred

11. If the incident occurred on a street or highway:

Name of street or highway	Milepost number	At the intersection with or nearest intersecting street
---------------------------	-----------------	---------------------------------------------------------

12. State agency or department you believe is responsible for damage/injury:

---

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

---

---

---

14. Names and telephone numbers of all state employees having knowledge about this incident:

---

---

15. Names and telephone numbers of all individuals not already identified in #13 and #14 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.

---

---

16. Describe how the state of Washington caused your injuries or damages (**if your injuries or damages were not caused by the State, do not use this form. You must file your claim against the correct entity**). Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

---

---

---

---

---

---

---

---

---

---

17. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom? Please attach a copy of the report or contact information.

---

---

---

18. Names, addresses and telephone numbers of treating medical providers. Submit copies of all medical reports and billings.

---

---

---

---

19. Please attach documents which support the allegations of the claim.

20. I claim damages from Clark County in the sum of \$\_\_\_\_\_.

This Claim form must be signed by one of the following (check appropriate box).

- Claimant
- Person holding a written power of attorney from the Claimant
- Attorney in fact for the Claimant
- Attorney admitted to practice in Washington State on the Claimant's behalf
- 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)**

**Or**

\_\_\_\_\_  
**Signature of Representative**

\_\_\_\_\_  
**Date and place (residential address, city and county)**

\_\_\_\_\_  
**Print Name of Representative**

\_\_\_\_\_  
**Bar Number (if applicable)**

**Authorization for Release of Protected Health Information (PHI)  
to  
Clark County, 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 Office of Risk Management for purposes of processing my claim for damages filed with Clark County 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  
Initials 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  
Initials 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  
Initials 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  
Initials 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  
Initials also authorize a different time frame for this release to be valid. This permission is valid until my  
claim is resolved or closed by ORM.

---

*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

---

**To the Provider or Records Custodian:**

Please send legible copies of all records to:

Clark County  
Office of Risk Management  
PO Box 5000  
1300 Franklin St.  
Vancouver, WA 98666-5000



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

### 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**

# VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

CLAIMANT AND INCIDENT INFORMATION	CLAIMANT'S NAME <small>(A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)</small>				DATE OF ACCIDENT (mm/dd/yyyy)		TIME AM <input type="checkbox"/> PM <input type="checkbox"/>			
	CURRENT STREET (RESIDENCE) ADDRESS			CITY	STATE	ZIP	HOME PHONE WORK PHONE			
	(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT			CITY	STATE	ZIP	EMAIL			
	State/County/City (if applicable) where occurred		STREET OR HWY	MILEPOST NO.	INTERSECTION OR NEAREST STREET/ROAD					
YOUR VEHICLE INFORMATION (VEHICLE #1)	YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN CAR BE SEEN?		WHEN?			
	NAME OF VEHICLE OWNER		ADDRESS		CITY	HOME AND WORK PHONE				
	NAME OF DRIVER		ADDRESS		CITY	HOME AND WORK PHONE				
	DRIVER'S LICENSE NUMBER			STATE OF ISSUANCE		DATE OF EXPIRATION				
	DESCRIBE DAMAGE				ESTIMATE \$	YOUR INSURANCE COMPANY AND POLICY NO.				
	YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOWN					
OTHER VEHICLE INFORMATION (VEHICLE #2)	NAME OF OWNER		ADDRESS		CITY	PHONE				
	NAME OF DRIVER		ADDRESS		CITY	PHONE				
	DESCRIBE DAMAGE						ESTIMATE \$			
	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.									
OTHER NON-VEHICLE DAMAGE	NAME OF OWNER		ADDRESS		CITY	PHONE				
	DESCRIBE DAMAGE						ESTIMATE \$			
INJURED PARTIES	NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
				HOME WORK						
				HOME WORK						
				HOME WORK						
				HOME WORK						
				HOME WORK						
WITNESSES	NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)		ADDRESS		CITY	PHONE				
							HOME WORK			
							HOME WORK			
							HOME WORK			

**COMPLETE ALL DETAILS**

Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

---



---



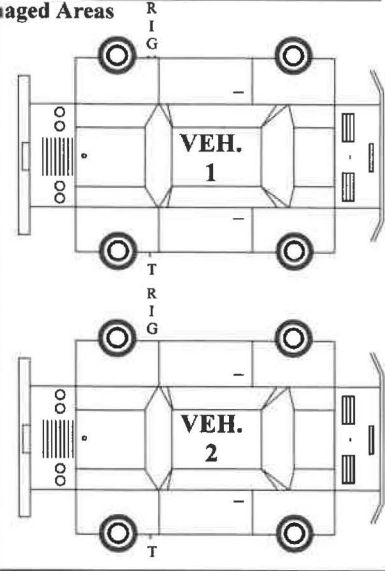
---



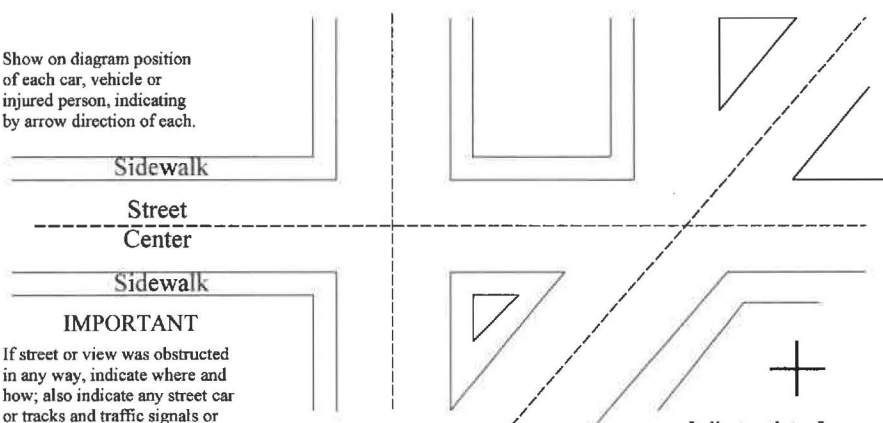
---



---

<input type="checkbox"/> Straight Road <input type="checkbox"/> Curve – R or L <input type="checkbox"/> Level	<input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill	<input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane	<b>Mark Damaged Areas</b> 
---------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.



**IMPORTANT**  
If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.

Indicate points of compass  
N. E. S. W.

LIGHT CONDITIONS (CHECK ONE)	TRAFFIC CONTROL	TYPE OF ROAD (CHECK ONE OR MORE)	VEHICLE CONDITION (CHECK ONE OR MORE)	ROAD SURFACE (CHECK ONE)	WEATHER (CHECK ONE)
1 <input type="checkbox"/> DAYLIGHT	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> SIGNALS	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> ONE WAY	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> DEFECTIVE BRAKES	VEHICLE NO. 1 NO. 2 1 <input type="checkbox"/> DRY	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	2 <input type="checkbox"/> STOP SIGN	2 <input type="checkbox"/> TWO WAY	2 <input type="checkbox"/> DEFECTIVE HEADLIGHTS	2 <input type="checkbox"/> WET	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	3 <input type="checkbox"/> FLASHING RED	3 <input type="checkbox"/> REVERSIBLE ROAD	3 <input type="checkbox"/> DEFECTIVE REAR LIGHTS	3 <input type="checkbox"/> SNOW	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	4 <input type="checkbox"/> FLASHING AMBER	4 <input type="checkbox"/> INTER-CHANGE LOOP RAMP	4 <input type="checkbox"/> TIRES WORN	4 <input type="checkbox"/> ICE	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	5 <input type="checkbox"/> RR SIGNAL	5 <input type="checkbox"/> ALLEY	5 <input type="checkbox"/> PUNCTURED OR BLOWN TIRES	5 <input type="checkbox"/> OTHER (SPECIFY)	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	6 <input type="checkbox"/> OFFICER/FLAGMAN	6 <input type="checkbox"/> TWO WAY-LEFT TURN LANES	6 <input type="checkbox"/> OTHER (SPECIFY)	NAME OF INVESTIGATING POLICE AGENCY: _____ INVESTIGATING AGENCY REPORT NO. _____	
7 <input type="checkbox"/> OTHER (SPECIFY)	7 <input type="checkbox"/> YIELD SIGN	1 <input type="checkbox"/> SEPARATED			
	8 <input type="checkbox"/> NO TRAFFIC CONTROL	2 <input type="checkbox"/> DIVIDED			
	9 <input type="checkbox"/> OTHER	3 <input type="checkbox"/> UNDIVIDED			

**A separate claim form should be submitted for each claimant.**

This information is being provided to aid in resolving the claim.

***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)*