LAKE CHELAN COMMUNITY HOSPITAL & CLINICS

Policy & Procedures

Title: LCCH Tort Claims

Affected Departments: Administration

Date Created:	**03/01/2016**	**Approved By: Kevin Abel (Chief Executive Officer)**
Last Review Date:	**03/30/2016**	
Pages:	**1 of 1**	

Purpose:

It is the policy for Lake Chelan Community Hospital and Clinics to follow the RCW 4.96.020 for tortious conduct of local governmental entities and their agents.

Policy:

As stated in RCW 4.96.020, the governing body of each local governmental entity shall appoint an agent to receive any claim for damages. The identity of the agent and the address where he or she may be reached during the normal business hours of the local governmental entity are public records and shall be recorded with the auditor of the county in which the entity is located.

Appointed Agent:	CEO
Office Address:	P.O. Box 908 503 E. Highland Ave Chelan, WA 98816
Business Hours:	8:00 am to 4:30 pm Monday – Friday except Holidays

All claims for damages must be presented on the standard tort claim form which is maintained in Lake Chelan Community Hospital's policy software program, Policy Tech, and available to the public, with instructions to file attached.

INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM

General Liability Claim Form

- ✓ 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.
- ✓ Provide all requested information and any available documents or evidence support 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:

1. Smith, Karen Michelle – 02/20/1965
2. 1234 College Way, NW, Apt 56, Chelan, WA 98816
3. P.O. Box 1234, Chelan, WA 98816-1234
4. 1234 College Way, NW, Apt 56, Chelan, WA 98816
5. 509-682-1234 - 509-682-5678
6. kmsmithWhotmail.com
7. 08/09/2016 - 8:30 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–Chelan - Chelan - Lake Chelan Community Hospital
10. I-5, Southbound, Milepost 109, near the Martin Way Exit
11. Witness, names, address, phone numbers
12. Hospital personnel, names, addresses and phone numbers
13. List all other witnesses having knowledge of the incident in question, with their names, addresses, and phone numbers that are not listed within items 11 and 12. 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, phone number, and indicate she witnessed the incident.
14. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
15. 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.
16. Please provide all of your medical providers with their names, addresses, phone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
17. Please attach any additional documents that support your claim.
18. 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.
- ✓ Sign, date & place of signature. 1234 College Way, NW, Apt 56, Chelan, WA 98816

LAKE CHELAN COMMUNITY
HOSPITAL & CLINICS

Standard Tort Claim Form

General Liability Claim Form

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against _____. Some of the information on this form is required by RCW 4.92.100 and may be subject to public disclosure. Pursuant to 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:

CEO
P.O. Box 908
503 E Highland Ave
Chelan, WA 98816
Phone: 509-682-8503
FAX: 509-682-2452
E-mail: kabel@lcch.net

Business Hours are: *Monday - Friday except for Holidays.*
8:00 am to 4:30 pm

CLAIMANT INFORMATION:

1. Claimants 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: _____ AM PM
   (mm/dd/yyyy) (circle one)
8. If the incident occurred over a period of time, date of first and last occurrences:
   from ____/____/_____ Time: _____ AM PM to____/____/_____ Time _____ AM PM
   (circle one) (circle 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. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

_____ Name	____-____-_____ Number	_____ Name	____-____-_____ Number
_____ Name	____-____-_____ Number	_____ Name	____-____-_____ Number
_____ Name	____-____-_____ Number	_____ Name	____-____-_____ Number

12. Names, addresses and telephone numbers of Hospital employees having knowledge of this incident.

13. Names address and telephone numbers of all individuals not already identified in #11 and #12 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.

14. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

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

16. Names, address and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

17. Please attach documents which support the claim's allegations.

18. I claim damages from PHD _____ in the sum of $_____.

This Standard Tort 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 the State of Washington on the Claimant's behalf, or by a court-appointed 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)

Authorization for Release of Protected Health Information (PHI)
To
Lake Chelan Community Hospital & Clinics

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 CEO of Lake Chelan Community Hospital & Clinics for purposes of processing my claim for damages filled with the state of 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)**

_____ initial I understand that my records are protected under HIPAA/PHI regulations (federal law) and the Washington State Health Care Information Act (RCW 70.02).

_____ Initial I understand that my health information may be subject to re-disclosure by the CEO and not protected for the purposes of evaluating and investigating the claim I have filed with the governmental entity.

_____ Initial 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 CEO in writing and that the
initial revocation will be effective as of the date the CEO 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
initial authorized a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed by Lake Chelan Community Hospital & Clinics

A Photostat of the Authorization carries the same authority as the original for purposes of releasing my records to the CEO of Lake Chelan Community Hospital & Clinics.

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:

CEO
P.O. Box 908
503 E. Highland Ave.
Chelan, WA 98816
FAX: 509-682-2452
E-mail: kable@lcch.net