

## **Mason County Fire District No. 6 Tort Claim Form Packet**

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

NOTE: all documents received by Mason County Fire District No. 6 become the property of MCFD6 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 MCFD6.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the MCFD6 State Tort Claim Form
2. MCFD6 Form
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, Mail or Fax the MCFD6 Claim Form & Supporting Documents to:

Mason County Fire District No. 6  
Attn: Richard Heinrich  
In Person: 50 E Seattle Street or Mail: PO Box 39  
Union, WA 98592  
Phone (360) 898-4871  
Fax (360) 898-4870

Business office hours: Monday-Friday, 8:00 a.m to 4:00 p.m Closed on weekends and holidays. PLEASE NOTE: Due to the nature of our business the business office may not have staff capable of taking this at all times. It is best to schedule an appointment.

**DUE TO THE COVID 19 PANDEMIC THE BUSINESS OFFICES ARE CURRENTLY CLOSED TO THE PUBLIC.  
PLEASE USE MAIL OR FAX TO SUBMIT AT THIS TIME.**

## **INSTRUCTIONS FOR COMPLETING A TORT 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. 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.

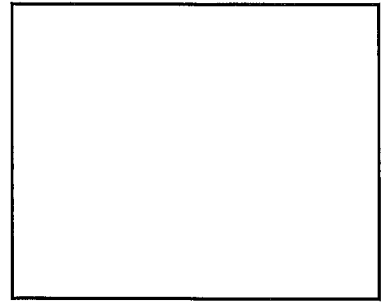
If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

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.

# MASON COUNTY FIRE DISTRICT NO. 6 TORT CLAIM FORM

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Mason County Fire District No. 6. 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, fax or deliver original claim to Mason County Fire District No. 6  
Attn: Richard Heinrich  
In Person: 50 E Seattle Street / Mail: PO Box 39  
Union, WA 98592  
Phone: (360) 898-4871  
Fax: (360) 898-4870

Business office hours: Monday-Friday, 8:00 a.m to 4:00 p.m Closed on weekends and holidays. PLEASE NOTE: Due to the nature of our business the business office may not have staff capable of taking this at all times. It is best to schedule an appointment.

**DUE TO THE COVID 19 PANDEMIC THE BUSINESS OFFICES ARE CURRENTLY CLOSED TO THE PUBLIC. PLEASE USE MAIL OR FAX TO SUBMIT AT THIS TIME.**

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)  
 to \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.  
 (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. 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 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 department caused your injuries or damages (if your injuries or damages were not caused by MCFD6, 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 Mason County Fire District No. 6 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  
Mason County Fire District No. 6**

Name: \_\_\_\_\_  
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month \_\_\_\_ Day \_\_\_\_ Year \_\_\_\_\_

I hereby authorize disclosure of my protected health information to Mason County Fire District No. 6 for purposes of processing my claim for damages filed with MCFD6.

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 or 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 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 not protected for purposes of evaluating and investigating the claim I have filed with Mason County Fire District No. 6.

\_\_\_\_\_ 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 Risk Management in 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 also authorize a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed MCFD6.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Mason County Fire District No. 6.

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

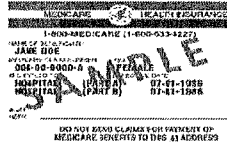
**To the Provider or Records Custodian:** Please send legible copies of all records to:  
Mason County Fire District No 6. PO Box 39 Union, WA 98592 Fax: 360-898-4870

## 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>															
Full Name: (Please print the name exactly as it appears on the SSN or Medicare card if available.)															
_____															
Medicare Claim Number:								Date of Birth(Mo/Day/Year)							
Social Security Number: (If Medicare Claim Number is Unavailable)										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.

<b>CLAIMANT AND INCIDENT INFORMATION</b>	CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)				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					
<b>YOUR VEHICLE INFORMATION (VEHICLE #1)</b>	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.				
<b>OTHER VEHICLE INFORMATION (VEHICLE #2)</b>	YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOWN					
	NAME OF OWNER		ADDRESS		CITY	PHONE				
	NAME OF DRIVER		ADDRESS		CITY	PHONE				
	DESCRIBE DAMAGE						ESTIMATE \$			
<b>OTHER NON-VEHICLE DAMAGE</b>	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.									
	NAME OF OWNER		ADDRESS		CITY	PHONE				
	DESCRIBE DAMAGE						ESTIMATE \$			
<b>INJURED PARTIES</b>	NAME	ADDRESS	PHONE	INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
				HOME WORK						
				HOME WORK						
				HOME WORK						
				HOME WORK						
				HOME WORK						
<b>WITNESSES</b>	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.

---



---



---

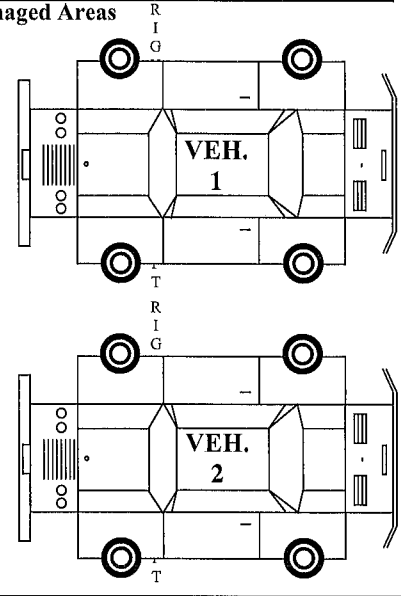


---

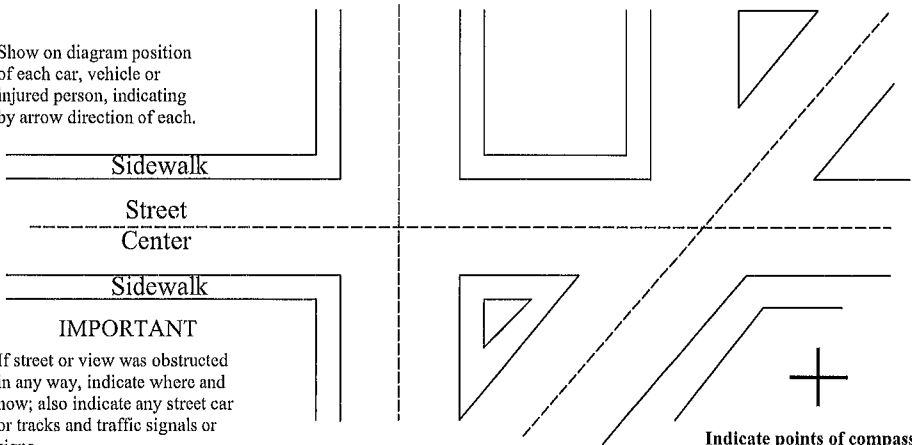


---

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



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