TORT CLAIM NOTICE, COUNTY OF CUMBERLAND, NEW JERSEY
N.J.S.A. 59:1-1, et seq.
To be completed and returned to:
Cumberland County Clerk to the Board
c/o Legal Department
164 W. Broad Street
Bridgeton, NJ 08302
johnca@CumberlandCountyNJ.gov

NOTICE:
ALL INFORMATION REQUESTED BELOW IS REQUIRED TO BE SUBMITTED. THE COURTS OF THIS STATE HAVE RULED THAT FAILURE TO COMPLY WITH THIS REQUIREMENT MAY INVALIDATE ANY CLAIM FOR DAMAGES. IF THE SPACE PROVIDED IS INSUFFICIENT TO PROVIDE A COMPLETE ANSWER, USE ADDITIONAL SHEETS.

1. CLAIMANT:

_____ _____
LAST NAME FIRST MIDDLE DATE OF BIRTH

_____

2. SOCIAL SECURITY NUMBER

3. ADDRESS: MAILING ADDRESS IF DIFFERENT:

_____ _____
STREET STREET

_____ _____
CITY STATE ZIP CITY STREET ZIP

_____ _____
HOME PHONE WORK PHONE

4. LOCATION OF INCIDENT: _____

_____

5. IF NOTICES AND CORRESPONDENCE ARE TO BE SENT TO A PERSON OTHER THAN THE CLAIMANT, TO WHOM AND WHERE SHOULD THEY BE SENT?

NAME: ADDRESS AND PHONE:

_____ _____

ATTORNEY AT LAW _____

OTHER RELATIONSHIP (DESCRIBE): _____

_____

DESCRIPTION OF INCIDENT

6. DATE OF INCIDENT:_____

7. TIME OF DAY:_____(A.M.) (P.M.)

8. EXACT LOCATION OF INCIDENT:_____

_____

9. DESCRIBE IN DETAIL HOW THE INCIDENT OCCURRED, STATING SPECIFICALLY WHY YOU CONTEND THAT CONDUCT OF THE COUNTY OR ANY OF ITS OFFICERS OR EMPLOYEES CAUSED OR CONTRIBUTED TO THIS INCIDENT. IF YOU KNOW THE NAMES AND/OR JOB TITLES OF ANY COUNTY OFFICIERS OR EMPLOYEES WHO YOU CONTEND WERE INVOLVED, PROVIDE THOSE NAMES OR JOB TITLES. IF NOT, PROVIDE SUGGICIENT INFORMATION SO THAT THOSE PERSONS CAN E INDENTIFIED.

_____

_____

_____

_____

_____

10. ON AN ADDITIONAL SHHET OF PAPER, DRAW A DIAGRAM OF THE WAY IN WHICH YOU CONTEND THE INCIDENT OCCURRED, NOTING ALL POINTS OF REFERENCE SUCH AS LANDMARKS AND POINTS OF INTERSECTION.

11. WAS THIS INCIDENT REPORTED TO THE POLICE? YES ___ NO___

12. WHEN WAS IT REPORTED? _____ WHICH DEPARTMENT?_____

13. POLICE CASE NUMBER: _____

14. ATTACH A COPY OF THE POLICE REPORT OF THE INCIDENT.

15. STATE THE NAMES AND ADDRESSES OF ALL PERSONS WHO WITHNESSED THE INCIDENT, USING ADDITIONAL SHEETS IF NCESSARY:

_____

_____

16. WERE ANY TICKETS ISSUED? YES___ NO___ IF SO, TO WHOM AND FOR WHAT?

_____

MEDICAL INFORMATION

17. DID YOU RECEIVE MEDICAL TREATMENT AS A RESULT OF THIS INCIDENT?
YES___ NO___

18. STATE THE NAMES OF ALL DOCTORS WHO TREATED YOU:

NAME	SPECIALTY	ADDRESS
_____	_____	_____
_____	_____	_____

USE ADDITIONAL SHEETS IF NECESSARY.

19. DO YOU CLAIM THAT YOU WERE INJURED AS A RESULT OF THE INCIDENT?
YES___ NO___

20. DO YOU CLAIM THAT ANY OF YOUR INJURIES ARE PERMANENT?
YES___ NO___

21. DID YOU RECEIVE INJURIES IN THIS INCIDENT WHICH ARE NOW CURED? IF SO, DESCRIBE THEM IN DETAIL AND STATE WHEN THEY WERE COMPLETELY HEALED:

_____

_____

_____

22. DESCRIBE IN DETAIL ALL INJURIES WHICH YOU SUFFERED AS A RESULT OF THIS INCIDENT WHICH YOU CLAIM TO BE PERMANENT AND DESCRIBE IN DETAIL ALL LIMITATIONS WHICH YOU CLAIM THOSE INJURIES PLACE ON YOUR ACTIVITIES:_____

_____

_____

23. HAVE ANY DOCTORS EXAMINED YOU (OTHER THAN THOSE NAMED IN 19. ABOVE) FOR THE PURPOSE OF EVALUATING THIS CLAIM, RATHER THAN STRICTLY FOR PURPOSES OF DIAGNOSIS AND TREATMENT? YES___ NO___

NAME	DATE	COPY OF REPORT ATTACHED?
_____	_____	YES___ NO___

IF REPORT IS NOT ATTACHED, WHEN WILL IT BE SUPPLIED?_____

USE ADDITIONAL SHEETS IF NECESSARY.

24. WERE YOU HOSPITALIZED AS A RESULT OF THIS INCIDENT? YES___ NO___

25. STATE THE NAMES OF ALL HOSPITALS WHERE YOU RECEIVED TREATMENT:
NAME ADDRESS DATES OF TREATMENT

_____

_____

_____

26. STATE IN DETAIL ALL COSTS FOR MEDICAL TREATMENT:
PROVIDER DATE OF TREATMENT AMOUNT

_____

_____

_____

_____

_____

27. ATTACH COPIES OF ALL MEDICAL AND HOSPITAL BILLS.

28. OF THE ABOVE COSTS, STATE THE AMOUNT WHICH IS NOT COVERED BY ANY POLICY OF INSURANCE: _____

29. LIST ALL INSURANCE POLICIES WITHIN THE HOUSEHOLD UNDER WHICH COVERAGE IS PROVIDED FOR ANY MEDICAL EXPENSE (INCLUDING MAJOR MEDICAL, AUTOMOBILE INSURANCE OR ELIGIBILITY FOR MEDICARE OR MEDICAID, PROVIDING THAT NAME OF THE INSURANCE PROVIDED TOGETHER WITH POLICY NUMBERS AND POLICY EFFECTIVE DATES):

_____

_____

INCOME INFORMATION

30. NAME AND ADDRESS OF EMPLOYER AT TIME OF INCIDENT:

_____

31. JOB TITLE:_____33. SALARY: _____

32. DO YOU CLAIM LOST WAGES OR INCOME AS A RESULT OF THIS INCIDENT?
YES___ NO___

33. AMOUNT OF LOST WAGES OR INCOME:_____

34. STATE IN DETAIL HOW YOU ARRIVED AT THE AMOUNT OF LOST INCOME CLAIMED, ATTACHING COPIES OF ALL PAY STUBS OR OTHER DOCUMENTATION AND DETAILING ALL TIME, IF ANY, LOST FROM WORK:

_____

35. DOES YOUR EMPLOYER PROVIDE MEDICAL COVERAGE? IF SO, PROVIDE THE NAME OF PROVIDER, GROUP PLAN, ETC.:

_____

OTHER PROCEEDING

36. HAVE YOU FILED ANY CLAIM IN ANY COURT (FOR EXAMPLE, WORKERS' COMPENSATION) AS A RESULT OF THIS INCIDENT? YES ___ NO ___

37. NAME OF COURT, DOCKET NUMBER: _____

38. HAS THIS MATTER BEEN RESOLVED? IF SO, DESCRIBE IN DETAIL:_____

_____

39. ATTACH A COPY OF ALL PLEADINGS OF ALL PARTIES IN THAT MATTER, AND ALL ORDERS GRANTING OR DENYING ANY RELIEF.

40. HAVE YOU FILED ANY CLAIM FOR STATE OR FEDERAL DISABILITY, SSI, UNEMPLOYMENT, OR OTHER BENEFITS? YES___ NO___
IF SO, WHERE? PROVIDE CLAIM NUMBER AND NAME OF AGENCY:_____

41. HAVE YOU SETTLED ANY PART OF THIS CLAIM WITH ANY OTHER PERSON, OR HAVE YOU AGREED TO ANY SETTLEMENT? IF SO, DESCRIBE IN DETAIL:

_____

_____

42. HAVE YOU FILED BANKRYPTCY OR ARE YOU CURRENTLY IN BANKRUPTCY? IF SO, AND YOU HAVE BEEN DISCHARGED, PROVIDE DETAILS (WHO,WHEN, ETC.):

_____

_____

PROPERTY DAMAGE

43. DO YOU CLAIM THAT ANY OF YOUR PROPERTY WAS DAMAGED AS A RESULT OF THIS INCIDENT? YES ___ NO ___

44. DESCRIBE SPECIFICALLY THE PROPERTY WHICH WAS DAMAGED, AND ITS VALUE BEFORE AND AFTER THE INCIDENT, ATTACHING COPIES OF ALL REPAIR ESTIMATES AND OTHER DOCUMENTATION OF THE LOSS:

_____

_____

45. ARE YOU COVERED BY INSURANCE FOR ANY OF THIS LOSS? YES ___ NO ___

46. NAME OF CARRIER_____POLICY NO._____

47. ATTACH A COPY OF THE INSURANCE POLICY PAGE STATING COVERAGES AND POLICY LIMITS.

EXPERTS

48. HAVE YOU RETAINED ANY EXPERTS (OTHER THAN DOCTORS NAMED ABOVE) TO ADVISE OR RENDER ANY REPORTS TO YOU OR YOUR ATTORNEY WITH RESPECT TO ANY MATTER RELEVANT TO THIS CLAIM? YES ___ NO ___

NAME ADDRESS AREA OF EXPERTISE

_____

_____

_____

49. IS THE EXPERT'S REPORT, OR A SUMMARY OF VERBAL FINDINGS, ATTACHED? YES ___ NO ___ IF NOT, WHEN WILL IT BE SUPPLIED?_____

ATTACH ADDITIONAL SHEETS IF NECESSARY.

REQUIRED ADDITIONAL INFORMATION

50. IN ADDITION TO THE INFORMATION REQUIRED ABOVE, YOU ARE REQUIRED TO PROVIDE THE FOLLOWING WITH RESPECT TO YOUR CLAIM:

A. A WRITTEN REPORT FROM YOUR TREATING PHYSICIAN, STATING THE NATURE AND EXTENT OF YOUR INJURIES, DETAILING ALL TREATMENT GIVEN TO DATE, STATING SPECIFICALLY THE TYPE AND CAUSE OF ALL DISABILITY, EITHER TEMPORARY OR PERMANENT, RESULTING FROM THE INCIDENT, AND STATING IN DETAIL ALL LIMITATIONS ON ACTIVITY, TEMPORARY OR PERMANENT, RESULTING FROM THE INCIDENT. THE REPORT MUST ALSO STATE THE NATURE, EXPECTED DURATION, AND THE ANTICIPATED RESULTS OF ANY FURTHER TREATMENT.

B. YOU ARE REQUIRED TO SIGN THE THREE AUTHORIZATIONS ATTACHED TO THIS CLAIM FORM. THE AUTHORIZATION TO OBTAIN MEDICAL RECORDS PERMITS THE COUNTY, OR ITS REPRESENTATIVES, TO OBTAIN COPIES OF ALL MEDICAL RECORDS WITH RESPECT TO YOUR PRESENT MEDICAL CONDITION AND TREATMENT GIVEN FOR YOUR CLAIMED INJURIES. THE AUTHORIZATION TO OBTAIN WAGE AND INCOME INFORMATION PERMITS THE COUNTY OR ITS REPRESENTATIVES TO OBTAIN INFORMATION REGARDING YOUR CLAIMED LOSS OF INCOME FROM YOU EMPLOYER OR OTHER SOURCES. THE CONSENT TO EXAMINATION PERMITS THE COUNTY TO SCHEDULE AN APPOINTMENT FOR YOU, AT THE COUNTY'S EXPENSE, TO BE EXAMINED BY A PHYSICIAN OR PHYSICIANS CHOSEN BY THE COUNTY IN ORDER TO VERIFY ALL MEDICAL INFORMATION PROVIDED AND TO DETERMINE YOUR PRESENT CONDITION. EVERY EFFORT WILL BE MADE TO SCHEDULE THIS APPOINTMENT AT A CONVENIENT TIME AND PLACE.

C. THE INFORMATION YOU PROVIDE WILL BE USED BY THE COUNTY TO EVALUATE YOUR CLAIM. ALL INFORMATION SET FORTH ON THIS FORM IS BINDING AND WILL BE RELIED UPON BY THE COUNTY, BOTH NOW AND IN THE FUTURE SHOULD THIS MATTER GO TO COURT, UNLESS IT IS SPECIFICALLY DISCLAIMED IN WRITING. IF THERE IS ANY FURTHER INFORMATION WHICH YOU BELIEVE WOULD BE HELPFUL IN REACHING A FAIR RESOLUTION OF THIS MATTER, PLEASE PROVIDE SAME EITHER BY ATTACHING IT TO THIS FORM OR WHEN IT BECOMES AVAILABLE.

D. ALL REQUESTS MADE ARE CONTINUING IN NATURE. IF ANY INFORMATION COMES INTO YOUR POSSESSION OR THAT OF YOUR ATTORNEY WHICH MAKES ANY INFORMATION ON THIS FORM INCOMPLETE OR INACCURATE, YOU OR YOUR ATTORNEY ARE OBLIGATED TO PROVIDE THAT INFORMATION TO US UNTIL SUCH TIME AS THE COUNTY HAS ADVISED YOU OR YOUR REPRESENTATIVE OF ITS DECISION WITH RESPECT TO YOUR CLAIM.

CERTIFICATION

I HAVE READ THIS FORM IN ITS ENTIRETY AND ACKNOWLEDGE THAT THE PURPOSE OF SUBMITTING THIS CLAIM IS TO MAKE WRITTEN APPLICATION FOR PECUNIARY BENEFIT (THE PAYMENT OF MONEY) AND IS TO AID OFFICIALS OF THE COUNTY OF CUMBERLAND IN PERFORMING THEIR LAWFUL FUNCTION. I RECOGNIZE THAT THE NEW JERSEY CODE OF CRIMINAL JUSTICE, N.J.S.A. 2C: 38-3(B) MAKES IT A DISORDERLY PERSONS OFFENSE TO MAKE ANY WRITTEN FALSE STATEMENT WHICH I DO NOT BELIEVE TO BE TRUE, OR TO OMIT INFORMATION WITH THE PURPOSE EITHER TO CREATE A FALSE IMPRESSION OR TO MISLEAD PUBLIC OFFICIALS IN THE PERFORMANCE OF THEIR FUNCTIONS. I RECOGNIZE THAT THE INFORMATION I HAVE SUPPLIED WILL BE USED BY PUBLIC OFFICIALS TO EVALUATE THE MONETARY VALUE OF THIS CLAIM, AND THAT A SIX MONTH PERIOD IS PROVIDED BY LAW (N.J.S.A. 59:8-8) FOR REVIEW OF THIS CLAIM BY THE COUNTY BEFORE I MAY FILE SUIT. IF I SHOULD, EITHER PERSONALLY OR THROUGH MY ATTORNEY, RECEIVE INFORMATION OR OBTAIN DOCUMENTS THAT WOULD RENDER ANY STATEMENT MADE HERIN FALSE, MISLEADING, OR INCOMPLETE I WILL CAUSE THIS MATERIAL TO BE FORWARDED TO THE COUNTY AS SOON AS POSSIBLE. I CERTIFY THAT I HAVE READ THIS COMPLETED CLAIM FOR DAMAGES AND THAT ALL INFORMATION CONTAINED HERIN IS TRUE AND COMPLETE EXCEPT AS NOTED OTHERWISE IN MY ANSWERS. I RECOGNIZE AND ACKNOWLEDGE THAT IF THIS CLAIM IS SIGNED BY A PERSON ACTING ON MY BEHALF RATHER THAN BY ME, ALL STATEMENTS MADE ARE BINDING ON ME AS THOUGH I HAD SIGNED THIS CLAIM MYSELF.

DATED:_____

_____
SIGNATURE OF CLAIMANT OR
PERSON ACTING ON BEHALF OF
CLAIMANT

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

TO WHOM IT MAY CONCERN:

I HEREBY CONSENT AND REQUEST THAT THE BEARER OF THIS AUTHORIZATION BE PERMITTED TO EXAMINE AND OBTAIN COPIES OF ALL HOSPITAL AND MEDICAL RECORDS OF EVERY SORT AND KIND, AND INTERVIEW DOCTORS, ATTENDANTS, AND OTHER PERSONNEL REGARDING ALL MATTERS RELATING TO MY MEDICAL HISTORY, EXAMINATIONS, DIAGNOSIS, CARE, CONSULTATION AND TREATMENT.

I AM WILLING THAT A PHOTOCOPY OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL.

DATED: _____ _____

SIGNATURE

ADDRESS: _____

_____

CONSENT TO EXAMINATION

TO THE COUNTY OF CUMBERLAND:

I HEREBY CONSENT TO EXAMINATION BY A PHYSICIAN OR PHYSICIANS CHOSEN BY THE COUNTY OF CUMBERLAND OR ITS REPRESENTATIVES FOR THE PURPOSE OF DETERMINING MY PRESENT MEDICAL CONDITION AND EVALUATING THE CLAIM I HAVE MADE AGAINST CUMBERLAND COUNTY. I AGREE TO COOPERATE IN THE SCHEDULING OF THIS EXAMINATION AND BY APPEARING AT THE TIME AND PLACE SET F OR THE EXAMINATION ON REASONABLE NOTICE THEREOF.

DATED_____ _____

SIGNATURE

Authorization for Release of Medical Records

HIPAA Compliant / Pursuant to 45 CFR 164.508

THIS AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND DATED

TO: _____ RE: _____
Name of Healthcare Provider/Physician/Facility Patient Name

_____ _____

_____ _____

_____ _____
Date of Birth Social Security Number

I authorize the disclosure of all protected health information and I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected health information including the following:

☐ Complete patient chart/file including but not limited to office notes, treatment notes radiographic/diagnostic testing results etc.
☐ Complete patient chart/file including but not limited to office notes, treatment notes, radiographic/diagnostic testing results etc. from date of accident / / through the present.
[Provide description of information to be used or disclosed that identifies the information in a specific and meaningful fashion.]

Note: Release of "psychotherapy notes" as defined in 45 CFR 164.501 requires completion of separate authorization form.
Information about diagnosis or treatment for alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)
☐ Yes, disclose HIV/AIDS information OR ☐ No, do NOT disclose HIV/AIDS information
☐ Yes, disclose alcohol/drug abuse information OR ☐ No, do NOT disclose alcohol/drug abuse information
This protected health information is disclosed for the following purposes:
☐ This disclosure is made at my request in compliance with 45 CFR 164.508(c)(1)(iv).
Description of legal proceeding Tort claim against Cumberland County or its entities
_____
☐ Other (describe)
_____

You are authorized to release the foregoing records to the following representatives of Cumberland County and its entities in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Inservco Insurance Services, Inc.
Name of Representative

Third-party claims administrator (duly appointed via CCIC resolution)
Representative Capacity (e.g., Attorney, Records Requestor, Agent, etc.)

3150 Brunswick Pike
Street Address

Lawrenceville, NJ 08648
City, State and Zip Code

This authorization does not apply to psychotherapy notes.

I acknowledge that I have the right to revoke this authorization, in writing, by sending written notification to you at the above-referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer to be protected under HIPAA privacy rules.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization, unless a condition set forth at 45 CFR 164.508(b)(4) applies.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization shall be in force and effect until:

☐ Date:_____

☐ Event (describe): dismissal or settlement of claim_____

_____

_____Dated:_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority to Sign for Patient (attach documents that show authority)

_____Dated:_____

Witness Signature

CONSENT TO RELEASE FORM

_____,HEREBY AUTHORIZE THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS), ITS AGENTS AND/OR CONTRACTORS, TO DISCLOSE, DISCUSS AND/OR RELEASE, ORALLY OR IN WRITING, INFORMATION RELATED TO MY INJURY CLAIM DATED __/__/__ AND/OR SETTLEMENT, MEDICARE SET ASIDE, OR CONDITIONAL PAYMENTS TO INSERVCO INS. SERVICES, INC. THIS CONSENT IS FOR MY INJURY CLAIM DATED __/__/__ AND IS ON AN ONGOING BASIS. AN ADDITIONAL CONSENT TO RELEASE WILL NOT BE NECESSARY UNLESS OR UNTIL I REVOKE THIS AUTHORIZATION (WHICH MUST BE IN WRITING).

_____
CLAIMANT'S SIGNATURE

_____
PLEASE PRINT NAME HERE

_____
SOCIAL SECURITY NUMBER

_____
DATE SIGNED