



**WASHINGTON STATE
STANDARD TORT CLAIM FORM**
General Liability Claim Form #SF 210

**INSTRUCTIONS ON HOW TO PRESENT THE FORM TO SOUND TRANSIT
AND CONTACT INFORMATION FOR SOUND TRANSIT'S AGENT
TO RECEIVE ANY CLAIM FOR DAMAGES
RCW 4.96.020**

Any person or entity asserting a Claim against Sound Transit for tort damages may use either the Washington State Standard Tort Claim Form or the Sound Transit Claim Form. RCW 4.96.020. The Washington State Standard Tort Claim Form may be obtained from (1) the Washington State Risk Management Division of the Washington Department of Enterprise Services; (2) that Agency's web site; (3) Sound Transit's web site – www.soundtransit.org – Contact Us – Claim Forms, and (4) the Sound Transit Risk Management Division at 401 S. Jackson St., Seattle, WA 98104-2826.

If you choose to use the Washington State Standard Tort Claim Form, to properly present your claim to Sound Transit you must deliver the completed form, either in person or mail, by regular mail, registered mail, or certified mail, with return receipt requested, to the Sound Transit Board Administrator, Sound Transit's agent to receive claims for tort damages, and NOT to the Washington State Office of Financial Management, Risk Management Division, as appears on the form.

You must either deliver or mail the completed Washington State Standard Tort Claim Form to Sound Transit's agent within the applicable period of limitations within which an action (lawsuit) must be commenced.

The name, address, and business hours of Sound Transit's Agent are:

Ms. Katie Flores
Board Administration
Central Puget Sound Regional Transit Authority
d/b/a Sound Transit
401 S. Jackson St.
Seattle, WA 98104-2826

Business Hours: Monday through Friday: 8:00 a.m. to 5:00 p.m.
Closed on weekends and official Washington State holidays.

Standard Tort Claim Form Packet

Please *carefully read all of the information in this packet* before completing and submitting your Standard Tort Claim. Please note that no documents will be 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 a Standard Tort Claim Form Packet.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form (SF 210)
3. Medical Authorization
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

Submit the Standard Tort Claim Form and Supporting Documents by mail, fax or email to:

Department of Enterprise Services
Office of Risk Management 1500 Jefferson Street SE
MS 41466
Olympia, WA 98504-1466
Fax: 360-407-8022
Email: WashingtonStateTortClaimE-Filing@des.wa.gov

Business Hours: Monday-Friday, 8:00 a.m. to 5:00 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.

STANDARD TORT CLAIM FORM

General Liability Claim Form #SF 210

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 may be subject to public disclosure.

PLEASE TYPE OR PRINT CLEARLY IN INK

Mail or deliver original claim to Department of Enterprise Services
U.S. Risk Management
1500 Jefferson Street SE
MS 41466
Olympia, Washington 98504-1466

Business Hours: Monday – Friday 8:00 a.m. – 5:00 p.m.
Closed on weekends and official state holidays.

1. Claimant's name: _____

Last name	First	Middle	Date of birth (mm/dd/yyyy)
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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 _____ (mm/dd/yyyy)	Time: _____ (mm/dd/yyyy)	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
to _____ (mm/dd/yyyy)	Time: _____ (mm/dd/yyyy)	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
10. Location of incident: _____

State and county	City, if applicable	Place where occurred
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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 alleged responsible for damage/injury:

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

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

15. Names, addresses 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 the cause of the injury or damages. 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. Attach copies of all medical reports and billings.

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

20. I claim damages from the state of Washington in the sum of \$_____.

This 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 Washington State on the Claimant's behalf, or by a 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
Department of Enterprise Services, 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 Department of Enterprise Services, Office of Risk Management (Risk Management) for purposes of processing my claim for damages filed 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)**

_____ 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 RMD.

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:

Department of Enterprise Services
Office of Risk Management
1500 Jefferson Street SE
Olympia, WA 98504-1466
Fax: 360-407-8022
Email: WashingtonStateTortClaimE-Filing@des.wa.gov

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: <i>(Please print the name exactly as it appears on the SSN or Medicare card if available.)</i>																
[Grid for Full Name entry]																
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

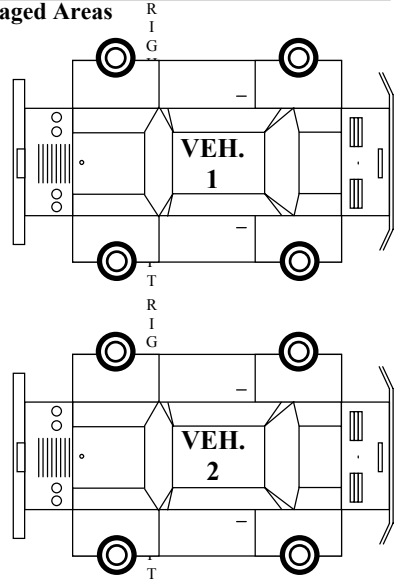
Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

CLAIMANT AND INCIDENT INFORMATION	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		PHONE HOME WORK	
	(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.				
OTHER VEHICLE INFORMATION (VEHICLE #2)	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 \$				
OTHER NON-VEHICLE DAMAGE	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.											
	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				

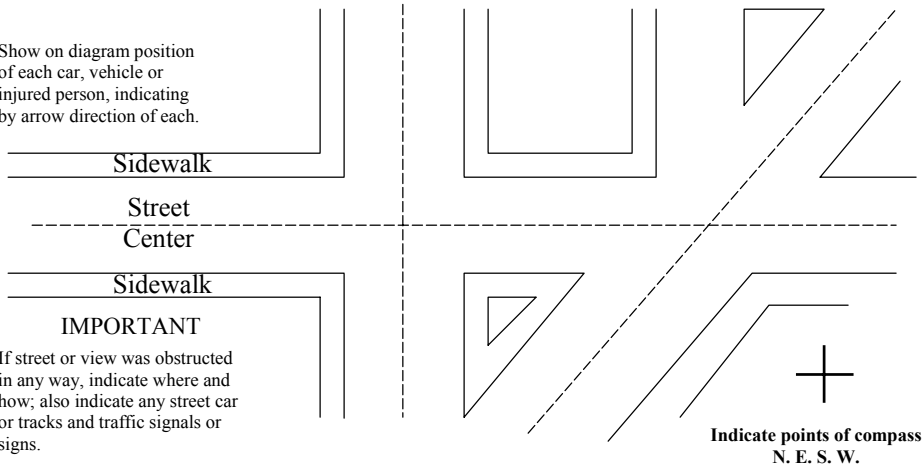
COMPLETE ALL DETAILS

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"/> Hillcrest | <input type="checkbox"/> One Lane | Mark Damaged Areas |
| <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	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	<input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS	<input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY	<input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES	<input type="checkbox"/> 1 <input type="checkbox"/> DRY	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	<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	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	<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	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	<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	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	<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)	
7 <input type="checkbox"/> OTHER (SPECIFY)	<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)		
	<input type="checkbox"/> 7 <input type="checkbox"/> YIELD SIGN	<input type="checkbox"/> 1 <input type="checkbox"/> SEPARATED		NAME OF INVESTIGATING POLICE AGENCY:	
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED		INVESTIGATING AGENCY REPORT NO.	
	<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)

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File a Tort Claim

Filing a Tort Claim

Individuals who have been harmed or who have suffered a loss as a result of negligent actions by a state employee or agency can submit a tort claim to the Office of Risk Management (ORM). ORM is required by law ([RCW Chapter 4.92](#)) to receive these claims.

ORM objectively determines the state's liability for claimed injuries. It fairly compensates claimants for damages when liability is supported by evidence and denies claims when liability is unsupported. ORM recognizes its stewardship role in protecting state resources by striving for efficient and timely service to citizens. Approved claims are paid out of the Self-Insurance Liability Program (SILP), which is funded by state agencies.

The Washington State Tort Claim Form is for use only if you believe that you were harmed by the state of Washington, its officers, employees, or volunteers. DO NOT USE THIS FORM if you were harmed by another entity (for example, the United States Government, another country, another State, a county, city, or private citizen). You must file your claim against the other entity or entities.

Documents will not be returned, please keep copies of everything you submit.

How to file a Washington State Tort Claim

Complete the [Washington State Tort Claim form](#) and submit by one of the methods listed below.

Submit Tort Claim in person:

Submit the completed [form](#) in person at the following address:

Office of Risk Management
Department of Enterprise Services
1500 Jefferson Street SE
Olympia, WA 98504-1466

Business hours: Monday – Friday 8:00 a.m. to 5:00 p.m. Office closed on weekends and official state holidays.

Submit Tort Claim by mail:

Submit the completed [form](#) by mail to the following address:

Office of Risk Management
Department of Enterprise Services
PO Box 41466
Olympia, WA 98504-1466

Submit Tort Claim by email:

- Complete the Form
- Type your signature onto the signature line
- Save the Form as a PDF document
- Open the saved Form and verify all the data has been saved to it
- Attach the completed Form to an email
- Put the Claimant's name in the subject line of the email
- Enter your name and contact information in the body of the email
- Ensure that any attachments to the email are in PDF format

- Email the Claim Form to:

The [Washington State Tort Claim](#) form may now be filed electronically pursuant to recent legislative changes to RCW 4.92.100 allowing the claim to be submitted as an attachment to electronic mail or by fax. Please do NOT mail an additional copy of the claim to DES.

Submit the completed form as an email attachment to the following email address: WashingtonStateTortClaimE-Filing@des.wa.gov. The email submittal must include the date, time the claim document was submitted, and the fax number from which it was sent.

Submit Tort Claim by Fax:

Submit the [completed form](#) to the following fax number: (360) 407-8022. The fax submittal must include the date, time the claim document was submitted, and the fax number from which it was sent. Please do NOT mail an additional copy of the claim to DES.

Additional information about email and Fax submissions:

If you need assistance submitting your tort claim electronically, you may contact ORM Customer Service at (360) 407-9199. Assistance is available Monday through Friday from 8:00 a.m. to 5:00 p.m. If assistance is required outside of these hours you can leave a voice message and contact telephone number. Voice messages will be responded to the following business day.

As of July 28, 2013, until further notice, ORM is unable to receive emails and attachments larger than 10 megabytes. If you attempt to submit an email and attachment larger than 10 megabytes, you will receive email notification that the message exceeds the domain's maximum per-message size limit. You should try to reduce the size of the message and resend it or submit the document in person or by regular mail delivery.

As of July 28, 2013, until further notice, ORM is unable to ensure that personal health or other confidential information received through the above email address or facsimile number is secure according to applicable privacy laws. You should not submit any personal health or other confidential information to ORM electronically.

Acknowledgement and follow-up questions

ORM acknowledges receipt of the Washington State Tort Claim by letter to the Claimant within approximately 10 days. For claim follow-up or acknowledgement questions, call (360) 407-9199.

Important items to note when completing the form

The [Washington State Tort Claim form](#) must be signed by one of the following:

- the Claimant
- a person holding a written power of attorney from the Claimant
- the attorney in fact for the Claimant
- an attorney admitted to practice in Washington state on the Claimant's behalf, or
- a court-approved guardian ad litem on behalf of the Claimant

The length of the Washington State Tort Claim investigation varies greatly depending on the complexity of the issues and the availability of documents and witnesses to support causation and damages. The tort claim can be resolved and closed quicker when all relevant information and documents are provided initially for the investigator's consideration.

Do not submit any documents that you wish to be returned to you. ORM will not return any documents submitted in support of your tort claim.

Checklist for filing your Washington State Tort Claim form

- ✓ Tort Claim form is typed or printed clearly in ink.
- ✓ Tort Claim form is filled out completely.
- ✓ If filing a claim for physical injuries, sign and return the attached "Authorization for Release of Protected Health Information."
- ✓ Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires that liability insurers (including self-insurers like the state of Washington) report specific information about Medicare beneficiaries who have other insurance coverage. If filing a claim for physical injuries, sign and return the attached "MMSEA Reporting Compliance Declaration." This is required for all claims for physical injuries regardless of claimant's Medicare eligibility status.

- ✓ If the claim involves a motor vehicle accident, complete, sign and return the attached “Vehicle Collision Form.”
- ✓ Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for physical injuries, photographs, proof of ownership for property damages, receipts for property value, etc.
- ✓ Sign, date and provide residential address, city and county of claimant. If submitting electronically, be sure claimant's name is in the email subject line and contact information is included in the body of the email.

Frequently Asked Questions (FAQ)

Recent legislative changes to RCW 4.92.100 permit claims for tortious conduct brought against Washington state to be submitted electronically as an attachment to email or by fax to the Department of Enterprise Services, Office of Risk Management (ORM). Citizens may also file tort claims in hard copy form by mailing or delivering the original documents to:

Department of Enterprise Services
Office of Risk Management
1500 Jefferson Street SE
PO Box 41466
Olympia, WA 98504-1466
Fax: (360) 407-8022
Email: WashingtonStateTortClaimE-filing@des.wa.gov

Business Hours: Monday – Friday 8:00 a.m. to 5:00 p.m. ORM is closed on weekends and official state holidays.

1. When can I file a claim?

The Washington State Tort Claim form is for use only if you believe that you were harmed by the state of Washington, its officers, employees, or volunteers. DO NOT USE THIS FORM if you were harmed by another entity (for example, the United States Government, another country, another State, a county, city, or private citizen). You must file your claim against the other entity or entities.

2. What is the email address where I can send my Washington State Tort Claim form?

WashingtonStateTortClaimE-filing@des.wa.gov

3. What is the fax number I can use to send my Washington State Tort Claim form?

360-407-8022

4. Are there restrictions I need to be aware of before I submit my Washington State Tort Claim form electronically?

Yes. As of July 28, 2013, until further notice, ORM is unable to receive emails and attachments larger than 10 megabytes. If you attempt to submit an email and attachment larger than 10 megabytes, you will receive email notification that the message exceeds the domain's maximum per-message size limit. You should try to reduce the size of the email and attachments to resend or file the tort claim in hard copy form by mailing or submitting in person.

5. Who should I contact if I need assistance filing my tort claim form?

ORM Customer Service is available Monday through Friday from 8:00 a.m. to 5:00 p.m. at (360) 407-9199. If assistance is required outside of these hours, you can call the Customer Service telephone number and leave a voice message and contact telephone number. These voice messages will receive a response the following business day.

6. Will my personal health or other confidential information I send be protected if I send it electronically?

No. As of July 28, 2013, until further notice, ORM is unable to ensure that personal health or other confidential information received through the above email address or facsimile number is secure according to applicable privacy laws. Therefore, you should not submit any personal health or other confidential information to ORM electronically.

7. What about the statutory requirement to have an original signature on the claim form?

When you sign the Washington State Tort Claim form, you are declaring under penalty of perjury under the laws of the state of Washington that information contained in your tort claim is true and correct. If submitting the tort claim in hard copy form by mail or in person, you must sign and date the claim. If the claim is submitted electronically, an electronic signature must be used. An electronic signature is defined as an original signature that is placed on the claim form and executed or adopted by the claimant with the intent to sign the form. ([Final Bill Report SB 5136](#))

8. Who is authorized to sign the tort claim form?

The claim form must be signed by one of the following:

- a. The claimant
- b. A person holding a written power of attorney from the Claimant
- c. The attorney in fact for the Claimant
- d. An attorney admitted in Washington on the claimant's behalf, or
- e. A court-approved guardian or guardian ad litem on the claimant's behalf

9. If I send my tort claim by email or fax, how will you able to verify it is coming from me?

When an electronic signature is used and the claim is submitted as an attachment to e-mail, the submittal of the claim must include the date, time, and email address from which it was sent. Please include the Claimant's name in the subject line of the transmittal email(s). If sent by fax, the submittal must include the date, time, and fax number from which it was sent.

10. Does it matter what format I use for the tort claim?

Yes. According to [RCW 4.92.100](#) all claims for damages must be presented on the [standard tort claim form](#) that is posted on the Department of Enterprise Services, Office of Risk Management website. If you submit your claim electronically, you must submit it in PDF format.

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