

**NOTICE OF CLAIM FOR DAMAGES AGAINST
THE CITY OF VINELAND**

1. Claimant:

Last Name,	First	MI	Date of Birth
Street Address			Alternate Mailing Address (If applicable)
City,	State	Zip Code	Social Security Number
Telephone Number			Alternate Telephone Number (If applicable)

If notices and correspondence in connection with this claim are to be sent to a person other than the claimant, complete item #2.

2.

Name	Mailing Address
City,	State
	Zip Code
Relationship to claimant:	Attorney at Law <input type="checkbox"/>] Other <input type="checkbox"/>] Explain _____

3. The occurrence or accident that gave rise to the claim:

a.

Date	Time
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b. Describe the exact location or place of the occurrence or accident:

c. Who owns this exact location or place?

d. Describe exactly how the occurrence or accident happened; if a diagram will assist your description, please attach illustration to this form:

e. State the name and address of the City of Vineland agency or agencies that you claim caused your damage:

f. State the names of City of Vineland employees whom you claim were at fault, including any information that will assist in identifying and locating them:

g. State the negligence or wrongful acts of the City of Vineland agency and City employees which caused your damages:

h. State the name and address of all witnesses to the occurrence or accident:

i. State the names of all Police Officers and Police Departments who investigated the occurrence or accident:

4. Claim for damages:

a. Check appropriate box

Personal Injury Property Damage Other

If other, explain in detail _____

b. If you claim personal injury:

(1) Describe in detail your injury resulting from this occurrence or accident:

(2) Do you claim permanent disability resulting from this injury?

Yes No

If yes, describe the injuries believed to be permanent:

(3) For each hospital, doctor, or other practitioner rendering treatment, examination or diagnostic services, please state:

Name of hospital, doctor or other facility:	Address of hospital, doctor or other facility:	Date of treatment or services:	Amount of charges to date:	Amount paid or payable by other sources such as insurance:

(4) If future treatment is necessary, state anticipated expenses for each treatment:

(5) If you claim loss of wages or income as a result of the injury, state:

_____ Name of Employer	_____ Address of Employer
_____ Occupation	_____ Dates of employment
_____ Rate of Pay	_____ Dates of absence from work
_____ Total lost wages to date	_____ If out of work, anticipated return date

Please provide income tax returns of claimant for the last five (5) years.

(6) Note here any and all other losses or damages claimed:

c. If you claim property damage:

(1) Describe the property damaged:

(2) The present location and time when the property may be inspected:

(3) Date property acquired:

(4) Condition of property when acquired:

(5) Monetary value of property when acquired: \$

(6) Description of damage:

(7) Monetary value of property at time of damage: \$ _____

(8) Has the damaged property been repaired: Yes No

If yes, by whom, when, and the cost of repairs:

(9) Attach each estimate of repair costs to this form.

(10) Provide, in detail, the loss claimed by you for the property damage:

d. Provide, in detail, all other items of loss or damages claimed by you and the method by which you made this calculation:

5. The amount of the claim: \$ _____

6. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice? Yes No

If yes, provide the names and addresses of all persons, agencies, and insurance companies against whom you have made such claims:

7. Are any of the losses or expenses claimed herein covered by any policy of insurance?
 Yes No

If yes, for each such policy state the name and address of the insurance company, policy number and benefits paid or payable:

8. Have you received or agreed to receive any money from any person, agencies or insurance companies for the damages claimed herein?
[] Yes [] No

If yes, please provide the details of such agreement:

9. The following items must be submitted with this notice:
- (1) If applicable, copies of itemized bills for each medical expense and other losses and expenses claimed.
 - (2) If applicable, full copies of all appraisals and estimates of property damage claimed by you.
 - (3) If applicable, copies of all written reports of all expert witnesses and treating physicians.
 - (4) If applicable, a letter from your employer verifying your lost wages. If self-employed, a statement showing the calculations of your claimed lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, that I am subject to the full extent of punishment provided by law.

DATED: _____ SIGNED: _____
[] Claimant or [] person filing claim on behalf of claimant

**AUTHORIZATION TO DISCLOSE INDIVIDUALLY
IDENTIFIABLE HEALTH INFORMATION
[This form complies with the HIPAA Privacy Rule]**

TO:

I, _____ (DOB: _____) hereby authorize you to release the
Patient's Name

documents described below to:

City of Vineland
640 E. Wood Street
PO Box 1508
Vineland, NJ 08362-1508

- () Hospital records (photostatic or otherwise) including admission records, medical history, consultation notes, nurses/doctors notes, test/lab results, operative reports, prescriptions, x-ray reports, bills, discharge summaries, etc., inclusive of any and all records concerning psychiatric, drug, alcohol and/or HIV treatment.

- () Physician's office records, office notes, progress notes, etc., from the date of initial treatment and/or examination up to and including the present, inclusive of any and all records concerning psychiatric, drug, alcohol and/or HIV treatment.

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this Authorization at any time prior to your compliance with the request set forth herein, provided that the revocation is in writing. I understand that any revocation must include my name, address, telephone number, date of the Authorization and my signature and that I should send it to you.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and, in that case, will no longer be protected by HIPAA.

This Authorization expires upon your release of the information described above or thirty days after the Date of Authorization, as set forth below, whichever comes first.

Patient's Name

Date of Authorization