NOTICE OF TORT CLAIM

GENERAL INSTRUCTIONS:

Pursuant to the provisions of the New Jersey Tort Claims Act, this Notice of Tort Claim form has been adopted as the official form for the filing of claims against the City of Hackensack.

The questions are to be answered to the extent of all information available to the Claimant or to his or her attorneys, agents, servants, and employees, under oath. The fully completed Claim Form and the documents requested shall be returned to:

Hackensack City Clerk's Office
Hackensack City Hall
65 Central Avenue
Hackensack, NJ 07601

NOTE CAREFULLY: Your claim will not be considered filed as required by the New Jersey Tort Claims Act until this completed form has been filed with the Hackensack City Clerk's Office. Failure to provide the information requested, including such responses as "to be provided" or "under investigation" will result in the claim being treated as not being properly filed.

Timely Notice of Claim must be filed within 90 days after the incident giving rise to the claim.

This form is designed as a general form for use with respect to all claims. Some of the questions may not be applicable to your particular claim. For example, if your claim does not arise out of an automobile accident, questions regarding road conditions might not be applicable. In that event, please indicate "Not Applicable".

If you are unable to answer any question because of a lack of information available to you, specify the reason the information is not available to you. If a question asks that you identify a document, it will

be sufficient to furnish true and legible copy. Where a question asks that you "identify all persons," provide the name, address and telephone number of the person.

If you need more space to provide a full answer, attach supplementary pages, identifying the continuation of the answer with the number to the applicable question.

CLAIM FOR DAMAGES AGAINST THE CITY OF HACKENSACK

1. Claimant:_____
(Last) (First) (Middle)

Date of Birth:____/____/____

Married: ( ) Single: ( ) Spouse's Name:_____

Street Address:_____ Mailing address if other than street address

_____

City: _____ State:_____ ZIP:_____

Social Security No.:_____-_____-_____

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

2. Name:_____

Mailing Address:_____

_____

City: _____ State:_____ ZIP:_____

Relationship to claimant:_____

3. a. The occurrence or accident which gave rise to this claim occurred on:

Date:_____ Time:_____

b. Describe the location or place of the accident or occurrence:_____

_____

_____

Exact location of the occurrence:_____

_____

_____

_____

c. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.

d. State the name(s) of the CITY OF HACKENSACK employee(s) whom you claim were at fault, including any information that will assist in identifying and locating them.

e. State the negligence or wrongful acts of the CITY OF HACKENSACK employee(s) which caused your damages.

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

g. State the name of all police officers and police departments who investigated the accident and provide a copy of the police report.

4. a. Claim for Damages (check appropriate block)

( ) Personal Injury ( ) Property Damage

( ) Other – Explain in detail:_____

_____

_____

b. If you claim personal injury:

(1) Describe your injuries resulting from the accident or occurrence:

_____

_____

_____

_____

_____

_____

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

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

_____

_____

_____

_____

For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic services, state:

_____

_____

_____

_____

_____

_____

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

Name of employer:_____

Address:_____

_____

Your occupation:_____

Date employed:_____

Rate of Pay:_____

Date of absence from work:_____

Total lost wages to date:_____

If still out, expected date of return:_____

NOTE: If your claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income. If self-employed, a copy of your previous year's income tax records must be submitted.

(4) Set forth any and all other losses or damages claimed by you.

_____

_____

_____

_____

_____

_____

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 was acquired:_____

(4) Cost of property: $_____

(5) Value of property at time of the accident: $_____

(6) Description of damage:_____

_____

_____

_____

(7) Has the damage been repaired?_____

If so, by whom, when and costs of repairs._____

_____

(8) Attach estimate of repair costs to this form. Two estimates required if damages exceeds $750.00.

(9) Attach photographs of damaged property.

(10) Set forth in detail the monetary loss claimed by you for property damage.

d. Set forth in detail all other items of loss or damages claimed by you and the method by which you made calculation.

_____

_____

_____

_____

_____

_____

5. The total amount of your claim._____

6. Have you made a claim against anyone else for the losses or expenses claimed in this notice?

( ) Yes ( ) No

If yes, set forth the name and address of all persons and insurance companies against whom you have made such claims:_____

_____

Do you collect benefits from any Municipal, State or Federal Agency? ( ) Yes ( ) No

If so, what agency._____

7. Are any of the losses or expenses claimed herein covered by any policy of insurance?

( ) Yes ( ) No

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 anyone for the damages claimed herein? ( ) Yes ( ) No

If so, set forth the details of such agreement.

9. The following items must be submitted with this notice:

(1) Copies of itemized bills for each medical expense and other losses and expenses claimed.
(2) Full copies of all appraisals and estimates of property damages claimed by you.
(3) Copies of all written reports of all expert witnesses and treating physicians.
(4) A letter from your employer showing your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

10. Prior Claims:

Have you ever made a claim before against THE CITY OF HACKENSACK or anyone else?

( ) Yes ( ) No

If so, list date of accident, location, parties involved, insurance carrier and claim number.

_____

_____

_____

_____

_____

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 punishment provided by the law.

Dated:_____ _____

Claimant or persons filing
claim on behalf of claimant

(This must be signed by claimant or the parents of claimants who are minors)

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HOSPITAL, MEDICAL, INSURANCE AND PHARMACY RECORDS PURSUANT TO 45 CFR 164.508

Plaintiff/Patient's Name: _____

Date of Birth: _____ Social Security No. _____

Plaintiff/Patient's Current Address(es):

_____

_____

TO: [Name of Healthcare Provider, Physician, Facility]

_____

_____

_____

I hereby authorize the designated records custodian of the HIPAA covered individual or entity identified above to disclose all protected health information for review and evaluation in connection with a legal claim. I expressly request that you disclose, make available and furnish to **the attorneys, claims managers, investigators or agents of the City of Hackensack** full and complete copies of all records and reports regarding my medical condition and/or treatment spanning the time period of [date of birth] to the present, including but not limited to all information relating to AIDS and HIV status. This information includes but is not limited to medical records, copies of films (x-rays, photographs, photographic slides or otherwise) pathology slides, diagnostic reports and laboratory testing reports. No originals will be released. No pathology material will be released but you must notify the above attorneys as to the existence of such pathology material.

IF YOUR RECORDS CONTAIN RECORDS OR REPORTS RELATING TO PSYCHIATRIC, PSYCHOLOGICAL OR ANY OTHER MENTAL HEALTH COUNSELING OR TREATMENT, YOU ARE NOT AUTHORIZED AT THIS TIME TO RELEASE THOSE MATERIALS, BUT YOU MUST PROVIDE NOTIFICATION OF THE EXISTENCE OF SUCH MATERIALS TO DEFENSE COUNSEL CHECKED ABOVE AND TO MY ATTORNEY:

Attorney Name: _____

Firm: _____

Address: _____

_____

This protected health information is disclosed for the following purposes: My notice of tort claim filed against the City of Hackensack pursuant to N.J.S.A. § 59:8-1 et seq.

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 re-disclosure by the recipient and to no longer be protected under 45 CFR 164.508.

I understand that the covered entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in CFR 164.528.

This will further authorize you to provide updated medical records for the undersigned to the above individuals, firms and corporations through the expiration date for this authorization without additional authorization. A facsimile, copy or photocopy of this authorization shall authorize you to release the records herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Dated this _____ day of _____, 20_____

_____
Signature of Plaintiff or Personal Representative

_____
Print or Type Name of Plaintiff or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Plaintiff (attach documents which show authority)

STATE OF NEW JERSEY :
:
COUNTY OF :

SUBSCRIBED and sworn to before me this _____ day of _____, 20____.

_____
Notary Public
My Commission expires: