

SKAMANIA COUNTY CLAIM FOR DAMAGE FORM

CLAIMANT: THIS CLAIM MUST BE FILED WITH THE

SKAMANIA COUNTY CLERK OF THE BOARD
Skamania County Auditor's Office
Skamania County Courthouse
240 North West Vancouver Avenue, Room 27
Stevenson, WA 98648

FOR OFFICE USE ONLY:

CLAIM NO. _____

DATE FILED: _____

COPIES TO: _____

NO DAMAGES CAN BE PAID BY SKAMANIA COUNTY UNLESS THIS
FORM IS COMPLETE. THIS PROVISION CANNOT BE WAIVED.

ATTACHMENTS: YES(#) NO

1. ^{JIM} Name (including spouse if married): (Please Print)

~~JESSE A~~ CHAMBERLIN

2. P.O. Box 39 STEVENSON WA 98648
Address City State Zip

3. HM Phone: 427-4524 WK Phone: 360 891-5161 MSSG Phone: _____

4. Date and time of incident: JAN 2006

5. Location of incident:

6. Describe in narrative form and in detail exactly how the incident occurred:

MY DAUGHTER, JESSICA WAS REQUIRED TO TAKE A DRUG
TEST IN JAN. OF THIS YEAR & I THOUGHT SHE WAS
TAKING CARE OF GETTING THIS PAID BY THE PARKS & REC.
FROM WORKING AT THE SWIMMING POOL. AS THE BILLS KEPT
COMING I FINALLY DECIDED TO PAY IT. ON SEPT. 2, 2006, IT
WAS AFTER I PAID THAT SHE TOLD ME THE COUNTY WAS SUPPOSED
TO PAY. SEE INCLOSED LETTER FROM COUNTY & BILL STATEMENT
What is the amount of damages claimed arising out of the following circumstances
(Include estimates and bills, if available): \$93.50

SEE ATTACHED
CONTINUATION

8. Please list name and address of any and all witnesses or persons involved:
(Please Print)

LAILA ROLDRINE

9. Describe the damages or injuries you sustained as a result of the incident:

N/A

10. Was incident investigated by a police officer? Sheriff _____ State Patrol _____
City _____

NO

11. If a vehicle was involved in the incident, describe: Make _____
Model _____ Year _____ State _____ License No. _____
Insurance Company _____ Policy Number _____

12. Describe what you did after the incident occurred: N/A

13. Describe the conversations you had, if any, with County personnel during or after the incident occurred.

14. How did you identify the County as the party responsible for your damage?

JESSICA WAS WORKING FOR COUNTY & WAS ASKED
TO TAKE DRUG TEST

I certify under penalty of perjury under the laws of the State of Washington that the information contained in this claim is true and correct.

DATED THIS 19 DAY OF SEPT, 2006

James E. Chamberlain
Claimant's Signature

File Name: Commis/Risk Mang/Claims/Claim For Damages

NOTE: Personal property (car, etc.) damages are to be accompanied by 2 estimates for repair costs. The Skamania County Risk Manager will investigate this claim. The decision to honor this claim will be based upon that investigation. Making a false report or providing false evidence is a crime and punishable by fine and/or imprisonment. Additional pages may be attached if needed to answer the questions.

CONT. OF #6

ALONG W/ COPY OF CHECK
SENT TO QUEST DIAGNOSTICS

Unofficial
Copy



SKAMANIA COUNTY COMMUNITY EVENTS & RECREATION

Rock Creek Recreation Center • P.O. Box 790 • 710 SW Rock Creek Dr. • Stevenson, WA 98648
Website: www.skamaniacountyparks.com • Email: parks@co.skamania.wa.us

Jessica Chamberlain
PO BOX 39
Stevenson, WA 98648

September 11, 2006

RE: Medical Billing

Dear Jessica;

On June 9, 2006 I sent a letter to you at the above-mentioned address. The letter requested the original billing for the lab test conducted at Providence Hood River Memorial Hospital. To date I have not received this billing.

It is my understanding that your father has since paid this bill. In order to recoup the money paid for this bill your father needs to make a claim for damages with Skamania County. He can pick up the necessary forms to complete this process at the Skamania County Auditors Office.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Ann M. Lueders
Executive Assistant

cc: sbp, dv

DOC # 2006163032
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Quest
Diagnostics®

31003871 0005895 3802919013 6
CHAMBERLIN JESSICA A
PO BOX 39
STEVENSON, WA 98648-0039

46306



Page

Laboratory Invoice

For services not included in your physician's bill

Invoice Number **380291901**

Lab Code **PNV**

THIRD NOTICE

9/2/06

DELINQUENCY NOTICE

THIS BILL IS FOR LABORATORY TESTS ORDERED BY YOUR DOCTOR. WE HAVE MADE TWO PRIOR REQUESTS FOR PAYMENT OF YOUR PAST DUE BALANCE. AT THIS POINT YOUR ACCOUNT IS SERIOUSLY DELINQUENT. IN ORDER TO HALT FURTHER COLLECTION ACTION, PLEASE REMIT PAYMENT IN FULL OR PROVIDE AN EXPLANATION OF WHY YOU HAVE NOT MADE PAYMENT.

PLEASE SEND YOUR PAYMENT FOR THE AMOUNT DUE IMMEDIATELY. TO ENSURE THAT YOUR PAYMENT IS CORRECTLY APPLIED TO YOUR BALANCE DUE, PLEASE RETURN THE BOTTOM PORTION OF THIS LETTER IN THE ENVELOPE PROVIDED.

Patient Name	CHAMBERLIN JESSICA A
Date of Service	January 31, 2006
Amount Due	\$93.50
Payment Due Date	09/12/2006
Responsible Party	CHAMBERLIN JESSICA A
Requested by:	Q54284NICKOLAS,CHRISTINA
Invoice Date	August 22, 2006

If you have Medicare, Railroad Medicare or Medicaid as your primary or secondary insurance, please send us the information - see reverse side

For billing inquiries or to pay by phone:
Please have your invoice available for reference.

Weekdays 8AM - 6PM

1-866-846-4027

Fax: 1-800-601-6608

Or visit our website at

www.questdiagnostics.com

Se Habla Español 9AM-6PM Tiempo del Este

PATIENT AMOUNT DUE \$93.50

Tax ID # 38-2084239

The CPT codes provided are based on AMA guidelines and without regard to specific payor requirements.

▼ Please fold and tear payment coupon along perforation and remit with payment in the envelope provided. ▼

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7565

☒ Track your expenses...

<input type="checkbox"/> Clothing	<input type="checkbox"/> Food	<input type="checkbox"/> Transportation
<input type="checkbox"/> Credit Card	<input type="checkbox"/> Utilities	<input type="checkbox"/> Mortgage
<input type="checkbox"/> Entertainment	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other

☐ TAX-DEDUCTIBLE ITEM

Sept 2, 2000

Quest Diagnostic

Ninety three & 50/100

BALANCE FORWARD	
THIS ITEM	<i>93.50</i>
BALANCE	
DEPOSIT	
OTHER	
BALANCE FORWARD	

For enhanced security, your name and account number do not appear on this copy.

NOT NEGOTIABLE