Claim for Money or Damages Against the City of San Leandro

Control No._____

For City Use Only

Return Claim Form To:

City Clerk's Office
City of San Leandro
835 East 14th Street, San Leandro, CA 94577-3782
Phone: 510/577-3487 or 510/577-3324 FAX: 510/577-3340

This claim against a public entity must be presented as prescribed by Parts 3 and 4 of Division 3.6 of Title 1 of the Government Code of the State of California by the claimant or by a person acting on his/her behalf, as well as comply with the Medicare Secondary Payer Mandatory Reporting Provisions in Section III of the Medicare, Medicaid and SCHIP Extension Act of 2007 (see 42 U.S.C. 1395y(b)(T) & (8)).

You must use the form provided or another form that satisfies the requirements of California Government Code Sections 910 and 910.2, otherwise your claim may be returned The use of this form is not intended in any way to advise you of your legal rights or to interpret any law. If you are in doubt regarding your legal rights or the interpretation of any law, you may seek legal advice.

When failure to present a timely claim occurs (one not within the required statutory six (6) months after the accrual of the cause of action), a written application may be made for leave to present such claim in accordance with the Government Code. The application shall be presented within a reasonable time not to exceed one (1) year after the accrual of the cause of action and shall state the reason for the delay in presenting the claim. The proposed claim shall be attached to the application.

Claimant Information: (Please type or print clearly)

Gender: ( ) Female ( ) Male

Name: _____ Date of Birth: _____

Address: _____ Work: ( ) _____

City/State/Zip: _____ Home: ( ) _____

Notices to be sent to: ☐ Same as above ☐ Other (please indicate name, address, city, state, zip, phone number and relationship to claimant)

Incident Information:

Date of Incident: _____ Time of Incident: _____ am / pm

Where did incident occur?

Please provide a detailed description of what happened and attach additional pages if needed.

Complete this section if you are a Medicare, Medi-Cal, or SCHIP beneficiary:

Social Security # (last 5 digits) or Medicare HICN:

ICD-9 Diagnoses Code:

Body Part Code:

Witnesses: ☐ Yes ☐ No If Yes, list name(s), complete address(es), and phone number(s)

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Did the incident involve a City employee, vehicle, or other equipment? ☐ Yes ☐ No

If Yes, please list name and department (if known), vehicle number, type of equipment, etc.

Describe damage, injury, indebtedness, obligation, or loss incurred as of claim date.

Claim Information:

If the claim is less than $10,000 amount must be noted on "Total Amount of Claim" line.
If the claim amount is more than $10,000, no dollar amount need be included, but you must indicate whether jurisdiction would rest in the :

☐ Municipal Court (claim value of more than $10,000 but less than $25,000); or
☐ Superior Court (claim value of more than $25,000)

Total Amount of Claim:

List of Claim Items:
(Attach copies of all receipts/ quotes, and photographs.)

Amount	Description
$	
$	
$	
$	
$	
$	
$	
$	
$	

Declaration:

This claim shall be dated and signed by the claimant or by some person on his/her behalf. A claim relating to a cause of action for wrongful death, personal injury, damage to personal property, or growing crops shall be presented not later than six (6) months after the accrual of the cause of action. There may be other statutes governing this claim, including, but not limited to, certain Federal statutes. You may seek the advice of any attorney in connection with this matter. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Date _____ Signature: _____

Print Name: _____

Relationship (if other than claimant): _____