



COSUMNES COMMUNITY SERVICES DISTRICT

CLAIMS FORM

INSTRUCTIONS

Please provide an original of this claim form. The original, together with one copy of all attachments, are to be filed with the Clerk of the Board. Retain one copy for your records.

Please send the completed original claim form and any attachments to:

Cosumnes Community Services District
Attn: Clerk of the Board
8820 Elk Grove Blvd.
Elk Grove, CA 95624

The Clerk of the Board is the ONLY staff to which claims may be submitted. Claims are NOT to be sent to any other District staff or department.

Please fill out claim form as instructed. Missing information will delay the processing of your claim.

PROCEDURES

Claims received by the Clerk of the Board will be forwarded to the District's insurance provider. All claimants are then notified what action will be taken within 45 days (plus additional if claim was mailed), or otherwise notified as to the claim itself. If the claim is recommended for denial, you will be sent a letter notifying you of the action taken, and any further action necessary or available to you.

*****ALL CLAIMS ARE PUBLIC RECORD*****



COSUMNES COMMUNITY SERVICES DISTRICT

CLAIMS FORM

Agency Name: Cosumnes Community Services District Date Claim Received: _____

This form is provided pursuant to Government Code Section 910.4 (a)

SECTION 1: CLAIMANT INFORMATION

Name of Claimant: _____ Date of Birth: _____
Home Address: _____
City, State, Zip: _____
Daytime Phone: _____ Email: _____

SECTION 2: CLAIM INFORMATION

Date of Incident/Accident: _____ Date injuries, damages, or losses were discovered: _____

Location of Loss (Please specify in as much detail as possible. Ex: 5 feet east of west corner of Elmira Road and Peabody)

What did entity or employee do to cause this injury, damage, or loss?

What specific injury, damages, or other losses did you incur?

What amount of money is claimant seeking or, if the amount is in excess of \$10,000, which is the appropriate court of jurisdiction. Note: If Superior and Municipal Courts are consolidated, you must represent whether it is a "limited civil case" [see Government Code 910(f)]

How was this amount calculated? (Itemize and attach bills, repair estimates, receipts, etc. If claim is for vehicle damage, obtain and attach two (2) repair estimates)

What is your basis for claiming the District or District employee(s) are the cause of injury, damages or loss?

What are the name(s) of District employee(s) whom you allege caused your injury, damages or loss, if known?

Name, address and phone number of any witnesses who can substantiate your claim.

Any additional information that you believe might be helpful to the District in considering this claim.

SECTION 3: NOTICE AND COMMUNICATIONS

All notices and communications with regard to this claim will be directed to the Claimant shown in Section 1 above unless you complete the following to identify to whom further communication should be directed.

Name: _____ Relationship: _____

Home Address: _____

City, State, Zip: _____

Daytime Phone: _____ Email: _____

Section 72 of the Penal Code provides that, “every person who, with intent to defraud, presents for allowance or for payment to any State Board or Officer, or to any county, town, city, district, board or officer, authorized to allow or pay the same if genuine, any false or fraudulent claim, bill, account, voucher, or writing, is guilty of a felony.”

Claimant Printed Name

Claimant Signature

Date Signed

Note: If the claim is filed by someone on behalf of the claimant, the person making the claim on behalf of the claimant should sign above.

Completed Claims Forms must be submitted by personal delivery or by United States mail.