

CHAPTER 8: Business Operations
ADMINISTRATIVE PROCEDURE NO. 8.20.1 (AP 3810)

ADMINISTRATIVE PROCEDURE
San Mateo County Community College District

Subject: AP 8.20.1 Claims Against the District
Adoption Date: 6/13
References: Education Code Section 72502; Government Code Sections 900 et seq.,
910 et seq. and 935

1. Before anyone can sue a public agency, a claim for damages must first be filed with that public agency. The law covering claims against public agencies is described in Government Code Section 900, *et. seq.*
2. If the complaint is against any unit of the San Mateo County Community College District (College of San Mateo, Cañada College, Skyline College, or District Office), the claim needs to be filed with the District Office. A claim form is attached. The form must be completed fully, signed, and sent to the Office of the Executive Vice Chancellor, SMCCCD, 3401 CSM Drive, San Mateo, CA 94402.
3. Usually a claim must be filed within six months of the incident. If it will be longer than that, the claimant should contact an attorney for more information.
4. Claims against the District are investigated by the District’s legal and risk management advisors. Investigations usually take several weeks to complete.
5. The claimant will be notified in writing of the status of his/her claim. If the claim is denied by the District, the claimant can sue the District in Small Claims Court for up to \$5,000 (or in Superior Court for a larger amount). The suit must be filed within six months after the denial.
 - a. Bodily Damage Claim:
 - When a claim is received, inform the Executive Vice Chancellor (EVC), and the Third Party Administrator (TPA). Send a “Claim Form” (Attachment 1) to the claimant.
 - When the claim form is returned, notify EVC, and send a copy to TPA. TPA will give instructions on procedures for handling the claim.
 - Inform the Board Secretary that a Board report for the “Denial of Claim” will be on the agenda at the next Board meeting. The District has an obligation to respond to the claim within 30 days by law. (Attachment 2)
 - The day after the Board meeting, send a letter (Attachment 3) to the claimant. Be sure to send a copy to the TPA.
 - The TPA and EVC will determine how to proceed, depending on the claimant’s response.
 - b. Property Damage/Vehicle Accident:
 - When a claim is received, ask the claimant if a Property Loss Report or Accident Report (Attachment 4) has been submitted. If not, send the appropriate form to the claimant.
 - Estimate the extent of the damage.

AP 8.20.1 Claims Against the District (continued)

- Notify the insurance and the TPA if warranted.
- If the damage can be managed by the District, ask the claimant to submit two estimates of the repair.
- When the claim is settled, be sure the claimant sign the “Release Form” (Attachment 5).
- If the damage is big or questionable, follow the steps from #2 under the “Bodily Damage” above.

Actual forms can be found at:

<https://smccd.sharepoint.com/sites/dis/pub/PublicLibrary/District%20Information/Districtwide%20Forms%20and%20contracts/SMCCCD%20Claim%20and%20Loss%20Reporting%20Forms/SMCCCD%20Claim%20Form.pdf#search=Claims>

Attachment 1

CLAIM FORM

(Please type or print legibly in black or blue ink. Please do not use a pencil.)

Claimant's Name _____

Claimant's Address _____

City _____ State _____ Zip _____

Phone (____) _____

Amount of Claim \$ _____

Address to which notices are to be sent to Claimant (if different than above)

Date of Incident _____ Location of Incident _____

Describe how the incident occurred (including damage or loss)

Name of Public Employee(s) causing injury, damage or loss (if known)

Itemization of claim (total should equal the "Amount of Claim" stated above)

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
Total Claim	\$ _____

I declare under penalty of perjury that the foregoing is true and correct.

Dated at _____, California on _____, 20____

Signature of Claimant _____

SEND TO: Office of Executive Vice Chancellor, SMCCCD, 3401 CSM Drive, San Mateo, CA 94402

San Mateo County Community College District

July 27, 2011

BOARD REPORT NO. 11-

TO: Members of the Board of Trustees
FROM: Ron Galatolo, Chancellor-Superintendent
PREPARED BY: Kathy Blackwood, Executive Vice Chancellor, 358-6790

DENIAL OF CLAIM AGAINST THE DISTRICT BY [REDACTED]

On July 1, 2011, the District received a claim from [REDACTED] seeking reparation in the amount of \$10,000 for the medical cost. Mr. [REDACTED] alleges that he sustained injuries and damages when he stepped incorrectly on the top flight of the steps and fell down at College of San Mateo on February 24, 2011. He claimed that the step is not leveled. Mr. [REDACTED] was at the campus as a Head Coach for West Valley Community College for the track meet.

RECOMMENDATION

It is recommended that the Board of Trustees deny the Claim against the District of [REDACTED] and refer the matter to the District's insurance and legal advisors.

November 2, 2018

CERTIFIED MAIL NO. 7000 1670 0007 2143 5357

Name of Claimant
Address

NOTICE OF DENIAL OF CLAIM

SUBJECT: Claim Against Public Entity

NOTICE IS HEREBY GIVEN that the claim which you presented to the Governing Board of the San Mateo County Community College District on August 14, 2002 was rejected on September 25, 2002.

***** WARNING *****

Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. (see Government Code 945.6.)

You may seek the advice of attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately.

By Direction, Board of Trustees
San Mateo County Community College District

Kathy Blackwood
Executive Vice Chancellor

KB:sc

Attachment 4

Accidental Injury Report

Cañada <input type="checkbox"/> CSM <input type="checkbox"/> Skyline <input type="checkbox"/>	Sent to: SMCCCD 3401 CSM Drive San Mateo, CA 94402	
Date/Time of Injury:		
Campus Location:		
Injured Person's Name & Address:	Date of Birth:	
	SS#	
	Tel#:	
Student <input type="checkbox"/> Visitor <input type="checkbox"/> Employee <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	
Description of Accident:		
Description of Injury:		
Witness(es) Name & Tel#: (1)	(2)	
Was any care administered immediately after injury? By whom?		
Additional help summoned? College Nurse <input type="checkbox"/> 911 <input type="checkbox"/> Campus Security <input type="checkbox"/> Other <input type="checkbox"/>		
Insurance Coverage: yes <input type="checkbox"/> No <input type="checkbox"/> If yes, policy number: _____		
Claim form given? Yes <input type="checkbox"/> No <input type="checkbox"/>		
(Student Accident Insurance is a secondary. If the injured person has insurance, she/he must use hers/his.)		
Name of the Employee who prepare the form:	Signature:	Date:

Property Loss Report

San Mateo County Community College District Office of Executive Vice Chancellor (650) 358-6786 Fax: (650) 574-6574		Sent to: SMCCCD 3401 CSM Drive San Mateo, CA 94402	
Campus		Report Date:	
Room(s)/Area(s):		Probable Date/Time of Occurrence:	
Date/Time Discovered:		By Whom:	
Witness' Name & Address:		Witness' Tel#:	
Student <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/>		If visitor, purpose for being on Campus:	
Vandalism: <input type="checkbox"/> Theft: <input type="checkbox"/> Break-In: <input type="checkbox"/> Fire: <input type="checkbox"/> Weather: <input type="checkbox"/> Other: <input type="checkbox"/>			
Description of Damage:			
List Items Missing:			
Police(Security) Report: Yes: <input type="checkbox"/> No: <input type="checkbox"/>		Administrator: (signature)	
(Please note any other pertinent information on other side of paper and attached copies of other correspondence relating to incident.)			
For Business Office Use Only			
Facilities & Maintenance Dept.:			
Labor: _____ hours at _____ per hour. Total Labor: _____			
Business Dept: Materials to be purchased.			
Quantity	Description	Cost	PO#
Estimated cost of Damage:		Actual Cost of Damage:	
To be Reimbursed/Send Bill to:		Bill Sent by:	
		Date Sent:	
		Date Reimb. Received:	
Insurance Claim File#		Date Filed:	

RELEASE OF ALL CLAIMS

KNOW ALL MEN BY THESE PRESENTS:

That the Undersigned being of lawful age, for the sole consideration of **(amount)** to the undersigned in hand paid, receipt whereof is hereby acknowledged, do/does hereby and for my/our/its heirs, executors, administrators, successors and assigns release, acquit and forever discharge San Mateo County Community College District and his, her, their, or its agents, servants, successors, heirs, executors, administrators and all other persons, firms, corporations, associations or partnerships of and from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses, and compensation whatsoever, which the undersigned now has/have or which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen and unforeseen bodily and personal injuries and property damage and the consequences thereof resulting or to result from the accident, casualty or event which occurred on or about the ___ day of _____ at **(location)**.

It is understood and agreed that this settlement is the compromise of a doubtful and disputed claim, and that the payment made is not to be construed as an admission of liability on the part of the party or parties hereby released, and that said releasees deny liability thereof and intend merely to avoid litigation and buy their peace.

The undersigned hereby declare(s) and represent(s) that the injuries sustained are or may be permanent and progressive and that recovery therefrom is uncertain and indefinite and in making this Release it is understood and agreed, that the undersigned rely(ies) wholly upon the undersigned's judgment, belief and knowledge of the nature, extent, affect and duration of said injuries and liability therefore and is made without reliance upon any statement or representation of the party or parties hereby released or their representatives or by any physician or surgeon by them employed.

The undersigned further declare(s) and represent(s) that no promise, inducement or agreement not herein expressed has been made to the undersigned, and that this Release contains the entire agreement between the parties hereto, and that the terms of this Release are contractual and not a mere recital.

THE UNDERSIGNED HAS READ THE FOLLOWING RELEASE AND FULLY UNDERSTANDS IT.

CAUTION: READ BEFORE SIGNING BELOW

Signature: _____

Print Name _____

Witness: _____

Date: _____