County of Santa Cruz

OFFICE OF THE COUNTY COUNSEL

701 OCEAN STREET, SUITE 505, SANTA CRUZ, CA 960604068
(831) 464-2046 FAX: (831) 464-2116

DWIGHT L. HERR, COUNTY COUNSEL
CHIEF ASSISTANTS
Deborah Steen
Samuel Torres, Jr.

Assistants
Harry A. Oberhelman III
Marie Costa
Jane M. Scoff
Rahn Garcia
Tamyra Rice
Pamela Fyfe
Ellen Aldridge
Kim Baskett
Lee Gulliver
Dana McRae

GOVERNMENT TORT CLAIM

RECOMMENDED ACTION

Agenda April 27, 1999

To: The Board of Supervisors

Re: Claim of Ann Crowell, No. 899-115A

Original document and associated materials are on file at the Clerk to the Board of Supervisors.

In regard to the above-referenced claim, this is to recommend that the Board take the following action:

X 1. Deny the claim of Ann Croweil, No. 899-115A and refer to County Counsel.

_____ 2. Deny the application to file a late claim on behalf of _____ and refer to County Counsel.

_____ 3. Grant the application to file a late claim on behalf of _____ and refer to County Counsel.

_____ 4. Approve the claim of _____ in the amount of _____ and reject the balance, if any, and refer to County Counsel.

_____ 5. Reject the claim of _____ as insufficiently filed and refer to County Counsel.

cc: Not County Jurisdiction

RISK MANAGEMENT

By Janet McKinley

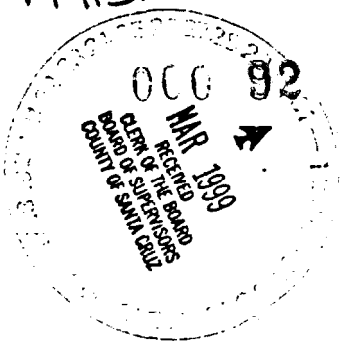
COUNTY COUNSEL

By

PER5107 wp rev. 4/99

899-115A

CLAIM AGAINST THE COUNTY OF SANTA CRUZ
(Pursuant to Section 910 et Seq., Govt. Code)



TO: BOARD OF SUPERVISORS
COUNTY OF SANTA CRUZ
ATTN: Clerk of the Board
Governmental Center
701 Ocean Street, Santa Cruz, CA 95060

1. Claimant's Name: ANN Crowell

Address: 328 OCEAN STREET APT. 6
SANTA CRUZ, CA. 95060

Phone No: 426-8104

P.O. Box to which notices are to be sent: Above address

2. Occurrence: BREACH OF CONTRACT

Date: 12/10/98 Place: SANTA CRUZ COUNTY

originating out of circumstances 1196
Circumstances of occurrence or transaction giving rise to claim: BREACH OF CONTRACT
failure to perform according to contract including both acts and non-action by said defendant(s) resulting in economic, physical and psychological damage

4. General description of indebtedness, obligation, injury, damage or loss incurred so far as is now known:
actual monetary loss (medical lien $50 /dvs/ obstruction of due process
physical and psychological damage
damage to reputation affecting future medical relationships

5. Name(s) of public employee(s) causing injury, damage or loss, if known: SANTA CRUZ County Managed Medical Care Commission operating as 'SANTA CRUZ County HEALTH OPTIONS' including but not limited to CAL DANIELS - REN WINTERS-

6. Amount claimed now ..... $ 2 million and fifty dolla

Estimated amount of future loss, if known ..... $

TOTAL $ 2million and fifty dollar

7. Basis for above computations: ① reimbursement for medical lien ② out of pocket fees for grievance adjudication / photocopy/documents/assistant/tran. etc) ③ physical + psychological damage ④ punitive damages because I

8. If the amount claimed is over $ 10,000, indicate the court of jurisdiction:

_____ Municipal Court _____ Superior Court

CLAIMANT'S SIGNATURE: Ann Crowell

Note: Claim must be presented to Clerk, Board of Supervisors, within six (6) months after the act which occasioned the injury.

Americans with Disabilities Act questions or requests for accommodations may be directed to the ADA Coordinator at 454-2962 (TDD 454-2 123).

PERSONNEL
15

RECLAMO CONTRA EL CONDADO DE SANTA CRUZ
(Segun Seccion 9 10 y Stguido de Codigo de Gohemacion)

OCT 93

A: BOARD OF SUPERVISORS, COUNTY OF SANTA CRUZ
ATTN: Clerk of the Board, 701 Ocean Street, Santa **Cruz,** CA 95060

1. Nombre de demandante _____

2. **Direccion** de demandante _____

_____

Numero de **telefono** de demandante _____

Caja postal donde se pueden mandar **las noticias** _____

3. **Incidente** _____

Fecha _____ **Lugar** _____

Circunstancias del incidente o **transaccion** que **resulto** de este reclamo _____

_____

_____

_____

_____

4. **Descripcion** general **tocante sus** deudas, obligaciones, lastimaduras, danos o **perdidas** que ha **sufrido hasta** la fecha

_____

_____

_____

5. (#) **Nombre(s)** de **empleado(s) publico(s)** quien han causado lastimaduras, danos, o perdida si son **reconocidas** por el **demandante** _____

DANITA CARLSON, Wells Shoemaker M.D ALAN MCKAY)

6. Cantidadreclamadaahastalafecha. ..... $_____

Estimacion de perdida **futura** (si sabe) ..... $_____

Total ..... $_____

7. (#) **Razones de tales calculaciones** WAS induced under duress and objection to Sign a misrepresented lien (5) Exemplary DAMAGES - for obstruction of due process - et.al. + oppression

8. Indique la **corte** de **jurisdiccion,** si el reclamo es **mas** de **$** 10,000

_____ **Corte** Municipal _____ **Corte** Superior.

_____
FIRMA DE DEMANDANTE

Nota Especial: **Este** reclamo **tiene** que ser presentada a: Clerk, Board of Supervisors, **#500, 70** 1 Ocean Street, Santa **Cruz,** antes de seis **meses** depues **del acto** que ha causado la perdida.

Prequntas **sobre** el Americans with Disabilities Act **(Acta** Americana de Incapacidades) o si necesita acomodaciones **llame** a la Coordinadora al # 454-2962 (TDD: 454-2 123).

PER5003S