State of Alabama

BOARD OF ADJUSTMENT

Instructions for Filing a Claim with the Board of Adjustment

Claims filed against departments, boards, commissions and instrumentalities of the State of Alabama must be filed on the Claim Form approved by the Board of Adjustment (Form A, Rev. 2002, or later). **Claims filed on other forms or Claims not meeting the following criteria WILL NOT BE ACCEPTED AND WILL BE RETURNED to the Claimant.**

1. Claims filed on a photocopied or faxed copy of a blank or uncompleted Claim Form will be accepted for filing ONLY if all parts of the Claim Form appear on the copy. All entries made by a Claimant on the Claim Form should be printed in ink or typewritten.

2. You **must** file the original Claim Form plus one (1) copy of the Claim Form with the Board. Two (2) copies of any supporting Documentation **must** be included with the Claim Forms.

3. The Claimant's **name, address and Social Security Number (FEIN if a business)** must be included in the spaces provided. If the Board of Adjustment authorizes an award, a check cannot be issued without this information. Claims without SSNs or FEINs cannot be processed and **will be returned** to the Claimant.

4. STATUTE OF LIMITATIONS. State Law prohibits the Board of Adjustment from considering most types of claims that arose more than one year before the date the Claim is **filed** with the Board. Generally, the Claim Form must be **received in the Board's office** within one year from the date of the accident or injury that is the basis of the Claim. **Line 3 or Line 4 on the Claim Form must be completed.** Completed Claim Forms may be faxed to the Board, within 30 days of the statute of limitations, only to establish the Date of Filing, however a Claim Form with original signatures must be filed with the Board within (10) days; otherwise, the Claim will be barred by statute and returned to you.

5. STATEMENT. The *Statement of Facts* [Line 6] must be completed so that the department the Claim is filed against can understand the basis of the Claim. The State agency the claim is filed against must also be included.

6. EXPENSES. Itemize all expenses claimed in section 7, 8 or 9. Include only those expenses that are specific to your claim. If requested information does not pertain to your claim, fill in the blank with N/A. The Board of Adjustment will not make awards for damage or injuries covered by private insurance. Complete information pertaining to insurance coverage must be included with the Claim Form. Total all expenses and enter that amount on line 10 of the Claim Form.

7. SIGNATURES. The claimant **must** sign the Claim Form (Line 12) and a Notary Public **must** sign the **Affidavit** under Line 12. Claim Forms not containing both **original** signatures will be returned. Claims with photocopied signatures will not be accepted.

8. SUPPORTING DOCUMENTATION. The Claimant is responsible for including copies of all documents needed to support his/her Claim. **Claim Forms that do not include two (2) copies of the required Supporting Documentation will be returned to the Claimant.** Examples of Supporting Documentation are listed on the reverse side.

THE DEPARTMENT THE CLAIM IS FILED AGAINST HAS 30 DAYS AFTER RECEIVING A COPY OF THE CLAIM TO FILE AN ANSWER WITH THE BOARD ADMITTING LIABILITY OR DISPUTING THE CLAIM. **The Board of Adjustment staff cannot settle your claim for you. The Board does not have money with which to pay claims. The payment of claims is the responsibility of the department the Claim is filed against ONLY IF liability is admitted by the department or determined by the Board.**

02/23/2007

EXAMPLES OF SUPPORTING DOCUMENTATION

The burden of proof rests with the Claimant. Submittal of supporting documentation is the responsibility of the Claimant and not the Board of Adjustment or the state agency against which the claim is filed. **TWO (2) COPIES ARE REQUIRED.**

Documentation may include, but is not limited to, the following:

1. **PROOF OF ACCIDENT/INJURY/INCIDENT**. An official accident/incident report, a report from a supervisor or some other official, any other evidence to prove that the incident upon which claim is based did take place. Date of accident/incident should be included.

2. **UNINSURED MEDICAL EXPENSES**. Evidence **(itemized bills)** to show what treatment was provided, when it was provided, and the charge, as well as evidence of insurance filing and payments (insurance company summary sheets or claims reports, etc.) indicating what was paid by your insurance must be included. **The Board of Adjustment will not make awards for injuries covered by private insurance. If claimant is not covered by insurance, this should be clearly stated.**

3. **PERMANENT DISABILITY**. Evidence (usually a letter, statement, or report from physician) that claimant has reached maximum medical improvement (MMI) and is left with a disability stated in percentage of physical impairment to the whole body or whatever part (arm, leg, finger, etc...) is involved. Also include verification from your employer of rate of pay at time of injury.

4. **LOST WAGES AND/OR COMPENSATION FOR LEAVE USED**. Evidence from doctor (or some other official) that claimant was unable to work because of the accident/injury stated, verification from the employer of the time lost from work or the leave deducted and verification from the employer of the claimant's rate of pay at the time of the accident/injury.

5. **DAMAGES TO PERSONAL PROPERTY**. Bills, receipts, estimates of repair, or any other document to substantiate the expense claimed. Identify the property involved (year, make and model of automobile, clothing, jewelry, etc.). If automobile, provide at least two estimates. **The Board of Adjustment will not make awards for damage covered by private insurance. Coverage information and deductible amounts must be provided.**

6. **MISCELLANEOUS/OTHER EXPENSES**. Evidence to support and substantiate whatever miscellaneous expenses the Claimant chooses to claim. Examples: unpaid invoices from a prior fiscal year, expense incurred for travel (31 cents/mile from 10/01/99-12/31/99; 1/1/2000 32.5 cents/mile; 1/1/2001 34.5 cents/mile; 1/1/2002 36.5 cents/mile; 1/1/2003 36 cents/mile; 1/1/2004 37.5 cents/mile; 1/1/2005 40.5 cents/mile; 9/1/2005 48.5 cents/mile; 1/1/2006 44.5 cents/mile; 1/1/2007 48.5 cents/mile for medical treatment or home care, or any expenses incurred which do not fit the listed categories. Provide complete explanation of expenses claimed.

7. **STATUTE OF LIMITATIONS**. Claims must be presented to the Board of Adjustment within one year after the date of the cause of action or within two years in claims for injury resulting in death.

The Board of Adjustment will not make awards for damage or injuries covered by private insurance. Complete information pertaining to insurance coverage must be included with the Claim Form.

Mail completed claim forms and all documentation in duplicate to:

STATE OF ALABAMA BOARD OF ADJUSTMENT
STATE CAPITOL
MONTGOMERY, AL 36130-1435
TELEPHONE (334) 242-7175/FAX (334) 242-2008

INSTRUCTIONS: Statute of Limitations is one year, if death is involved, two years. Give complete information and **attach all requested documentation** and any other information to substantiate your claim. The burden of proof rests with the claimant. Failure to provide complete information may affect the decision of your claim. **ALL CLAIMS MUST BE SIGNED AND NOTARIZED.** Submit two complete sets to: **STATE BOARD OF ADJUSTMENT, ALABAMA STATE CAPITOL, THIRD FLOOR EAST WING, MONTGOMERY, AL 36130-1435. PHYSICAL MAILING ADDRESS: 600 DEXTER AVENUE, SUITE 302, MONTGOMERY, AL 36104.**

Do not write in this space

CLAIM NO.: _____

SUPPLEMENT NO.: _____

If a SUPPLEMENT to a previously filed claim, give Claim Number: _____

_____

Name of Department/Agency

1. Name & Mailing Address of Claimant: _____

_____

Home Telephone: _____ Business Telephone: _____

Social Security/Federal I.D. No. (Required for issuance of state check): _____

If injured party is a minor (under 19 years of age), CLAIM MUST BE SIGNED AND FILED BY PARENT OR GUARDIAN AS CLAIMANT. Give name and age of minor and the name and relationship of person with whom minor lives.

_____

2. Claimant's Attorney (If representing claimant on this claim): _____

Mailing Address: _____

_____ Zip: _____ Telephone _____

Note: All correspondence and communication will be with claimant's attorney.

3. **Date of Accident or injury:** _____

4. **If not accident or injury, on what date did claim arise?** _____

5. **Where did injury or damage occur ?** _____
(county, city, building name, etc.)

6. **Statement of Facts:** Give the name of the department or agency of the State of Alabama involved. Tell in your own words exactly what happened to cause you to file this claim. **Attach a copy of accident/incident report.**

Prior Fiscal Year Invoices ☐ Yes ☐ No Travel Expense ☐ Yes ☐ No Other ☐ Yes ☐ No
Explain below.

Invoice/Reference #_____

Facts: _____

_____

_____

_____

_____

_____

(Attach additional sheets if needed.)

Form A
Revised 2/07

7. **IS CLAIM MADE FOR:** (Complete only those parts which apply to this claim.)

(A) **UNINSURED MEDICAL EXPENSES?** ☐ Yes ☐ No

Was this an on-the-job injury? ☐ Yes ☐ No
Did you receive any time off with pay? ☐ Yes ☐ No If yes, give dates: _____

Amount: $ _____ Do you have insurance? ☐ Yes ☐ No Company: _____

All medical expenses must be submitted to your insurance company: **Attach documentation to support the amount claimed, such as itemized bills and insurance company statement (s) showing the expenses have been filed and the amount paid or payable by insurance.**

(B) **PERMANENT DISABILITY?** ☐ Yes ☐ No

Amount: $ _____

Describe: _____
Attach detailed statement by a doctor or vocational expert describing extent of disability

Rate of pay at time of accident/injury: $ _____
Attach verification from employer.

(C) **LOST WAGES AND/OR COMPENSATION FOR LEAVE USED?** ☐ Yes ☐ No

Amount: $ _____ for _____ hrs./days/weeks/etc.

Period (dates) for which claim is made: _____

Rate of pay at time of accident/Injury: $ _____
Attach doctor's excuse for dates missed from work. Attach verification of dates and rate of pay from employer.

8. **DAMAGES TO PERSONAL PROPERTY?** ☐ Yes ☐ No

Amount: $ _____
Attach bills, receipts, etc. to substantiate amount claimed. If automobile, attach two estimates of repair costs.

Describe property: _____
(year/make/model of vehicle, watch, eyeglasses, clothing, etc.)

Do you have insurance which would cover all or part of the damage? ☐ Yes ☐ No

If yes, give name of insurance company: _____

Amount of coverage: _____ Deductible: _____
(Please attach copy of declaration page.)

Have you filed for coverage to which you are entitled under your policy? ☐ Yes ☐ No

9. **MISCELLANEOUS/OTHER EXPENSES?** ☐ Yes ☐ No

Amount: $ _____

Explain: _____

_____
Attach documentation to substantiate.

10. **TOTAL AMOUNT CLAIMED:** $ _____
This amount must be stated.

11. No part of this claim has been assigned by me and no amount has been paid to or received by me in payment for any damages/injury complained of herein except as set out as follows: (List amounts received from insurance or any other sources.)

____

12. Signature of claimant/representative: ____
Must bear original signature (not a machine copy) of claimant or his/her representative.

►►

STATE OF ________________________________ }

COUNTY OF _______________________________ }

AFFIDAVIT

Before me, a Notary Public in and for said state and county, personally appeared ______________________________ who being made known to me, and being informed of the contents of this petition and the statements by him/her therein, and being duly sworn, says such statements are true and correct.

Sworn and subscribed before me this ________________ day of __________________, 20 _________.

____
Signature and Seal of Notary Public