MC531
Attachment A

CLAIM FOR DAMAGE TO EMPLOYEE'S PERSONAL PROPERTY

A. GENERAL INFORMATION:
(Please print or type)

Reporting Form(s) Completed: ☐ Yes ☐ No
(See DHS POLICY 583.000 before completing Claim Form)

Today's Date:	Facility:	Division:	
Last Name:	First Name:	Employee No.:	Payroll Title:
Headquarter's Address:	City:	State:	Zip:	Phone:
Supervisor's Name:	Title:	Phone:	
Date of Incident:	Location of Incident:	Property Description:	
Describe How Damage Occurred:			

B. REIMBURSEMENT REQUEST INFORMATION: (See Allowable Reimbursement DHS POLICY 583.000)

☐ Repair/Replacement	Cost of Estimate #1: Cost of Estimate #2:	Two verifiable estimates with business letterhead, phone number and signature must be attached to Claim Form <u>if</u> reimbursement documentation not available and/or feasible.
☐ Other, please specify:	Cost:	Proof of original cost and or relevant supporting documentation must be attached.

CERTIFICATION and ASSIGNMENT: I certify that the facts contained on this form are true and complete to the best of my knowledge. I agree to subrogate to the Department of Health Services any right which I may have for reimbursement from others for the damage or destruction of the subject of this claim, to the extent of the amount paid to me by the Department. I understand that I will be reimbursed in accordance with "Allowable Limits" as defined on the Claim Form.

Employee's Signature Date	Supervisor's Signature Date
Claims' Manager Signature Date	Risk Manager's Signature Date

Revised: 10/30/20
Approved: 2/11/14; 5/9/17; 10/30/20; xx/xx/23