DHS Oregon Department of Human Services

Print Form

SHARED SERVICES
Office of Payment Accuracy and Recovery

Reset Form

Oregon Health Authority

Vehicle Related Personal Injury

State office use only:	Send original to Personal Injury Liens. Make copy for case record.				
	Program:	Branch:	Case number:	Caseworker name:	Worker phone:
	☐ Branch ☐ PIL		Injured person's prime no.:	Case name:	

1. Name and address of injured person:

2. Date of injury/accident:

3. Were you employed at time of accident? ☐ Yes ☐ No
Who was your employer:_____

4. Location/address where injury/accident occurred (include city and state):

5. Did you receive wage loss benefits? ☐ Yes Amount: $_____ ☐ No

5a. Did you have automobile medical insurance at the time of the accident? ☐ Yes ☐ No

6. Have you filed a personal injury claim? ☐ Yes ☐ No

6a. Has the claim been settled or resolved? ☐ Yes Amount: $_____ ☐ No Date settled: _____

7. Were your medical expenses covered by an insurance company other than Medicaid? ☐ Yes ☐ No
Claim number: _____ Insurance company name:_____

8. Your attorney's name:_____ Phone number:_____
Attorney's address: _____

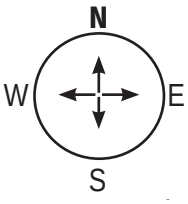
9. Were you? ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Bicyclist

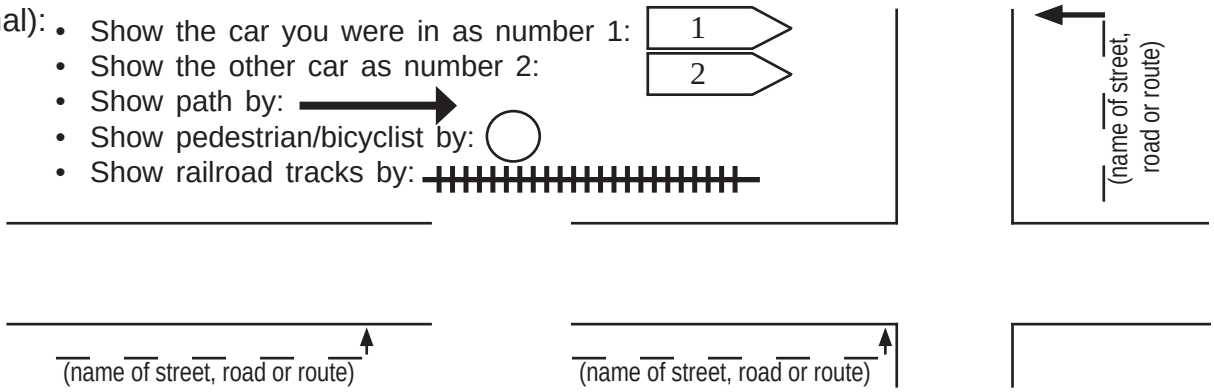
10.	Driver's	
	Vehicle 1: Injured person's vehicle	**Vehicle 2: Other vehicle**
Name:		
Address:		
City/State/ZIP:		
Phone number:		
Driver's insurance co.:		
Policy number:		
Claim number:		
Adjuster's name:		
Adjuster's phone:		

11.	Owner (if other than driver)	
Name:		
Address:		
City/State/ZIP:		
Phone number:		
Insurance company:		
Policy number:		
Claim number:		
Adjuster's name:		
Adjuster's phone:		

12. Diagram (optional):

- Show the car you were in as number 1:
- Show the other car as number 2:
- Show path by:
- Show pedestrian/bicyclist by:
- Show railroad tracks by:





13. Describe the accident:

14. List your injuries:

15. List any one else in your vehicle and their injuries.

16. Did the police investigate the accident? ☐ Yes ☐ No	16a. If yes, by whom? ☐ City Police ☐ State Police ☐ County Sheriff
17. Was a citation issued? ☐ Yes ☐ No	17a. Who received the citation and for what?

I understand the questions on this form. I have a copy of my Rights and Responsibilities. I understand my rights and what I must do. I know I must give true and complete information. I understand there are penalties for giving wrong or incomplete information. My answers are true and complete to the best of my knowledge. I agree to give the Department of Human Services (DHS) and Oregon Health Authority (OHA) proof of the statements I have made. I will let DHS|OHA contact other people and agencies to get proof I do not have.

Client's signature:	Date:	Client's phone number:

Purpose of form:

- To file a lien on any claim for damages resulting from the accident/injury.
- If you need help, contact your case worker.

Return to:

Personal Injury Liens
PO Box 14512
Salem Oregon 97309

Under Oregon law you must report all personal injury claims to us.

The Department of Human Services (DHS) and Oregon Health Authority (OHA) will not discriminate against anyone. This means DHS|OHA will help all who qualify. DHS|OHA will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS|OHA discriminated against you because of any of these reasons.

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