NEBRASKA

DEPT. OF ADMINISTRATIVE SERVICES

Standard Operating Procedures: How to File a Miscellaneous Claim Against the State of Nebraska

Department of Administrative Services
Risk Management

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State Miscellaneous Claims Act, Nebraska Revised Statutes §§ 81-8,294 to 81-8,301

Miscellaneous claim shall mean any claim against the State for which there is no other specific provision of law for the resolution of such claim.

Typical Miscellaneous Claims would be for:

- Damage to an employee's personal property.
- Reimbursement of an overpayment.
- Reimbursement of a State Employee's work-related expenses when not within 60 days to the responsible Agency.
- A Claimant who has paid the State of Nebraska for items or services the Claimant has not received.

All such claims or requests and supporting documents shall be filed with Risk Management. It is important to keep copies of all documents submitted as the Office of Risk Management does not return any documents to the Claimant.

All claims permitted under the State Miscellaneous Claims Act, excluding Uncashed Warrant Claims, shall be forever barred unless the claim is filed with Risk Management within two years after the time the claim occurred.

TO FILE A MISCELLANEOUS CLAIM:

Download the Miscellaneous Claim Form Here

Only fully completed and signed Miscellaneous Claim Forms will be accepted by the Office of Risk Management.

State of Nebraska Tort & Miscellaneous Claim Form

This form is for Tort (Neb. Rev. Stat. § 81-8,209 - § 81-8,235) and Miscellaneous (Neb. Rev. Stat. § 81-8,294 - § 81-8,301) Claims against the **State of Nebraska**.

Only **COMPLETED** and **SIGNED** Claim Forms will be accepted by the Office of Risk Management. * Indicates a **REQUIRED** field. If required fields are not filled out, your Claim will not be processed.	**FOR OFFICE USE ONLY** ☐ TORT ☐ MISCELLANEOUS Claim Number:

Claimant's Name*:	Claimant's Phone Number*:	Alternate Phone Number:
Claimant's Mailing Address*:	Claimant's Email Address:	Is Claim Work Related? ☐ YES ☐ NO
Is Claimant Medicare Eligible*? ☐ YES ☐ NO	Is Claimant a State Employee? ☐ YES ☐ NO	If YES, What State Agency?
Date of Occurrence*:	Total Amount of Claim*:	Place of Occurrence:
Do you have insurance covering this claim? ☐ YES ☐ NO	Insurance Deductible Amount:	
Name and Address of Insurance Company & Insurance Policy Number:		
Name, Address, and Phone Number of Attorney, if any:		

In the below space, please provide a detailed itemization of all known facts/circumstances/damages leading to your claim. Identify all property, places, and people involved. Include names, addresses, and phone numbers of witnesses, if any. The information provided below, along with the findings of the investigating agency, will form the basis of any decision.*

Claimant Signature*: Date*:

Under Penalties of law, I declare that I have examined this statement and that it is, to the best of my knowledge and belief, true, complete, and correct, and that I am duly authorized to sign this statement.

Please include copies of any supporting documents that may be relevant to your claim including, but not limited to, Photos, Invoices, Receipts, Police Reports, Estimates, Medical Bills, Expense Reports, etc.

Make and keep copies of all documentation submitted as copies will not be provided.

Claim form and supporting documents can be emailed to: as.riskmanagement@nebraska.gov
Or mailed to: Office of Risk Management, PO Box 94974, Lincoln, NE 68509-4974
Questions? Call the Office of Risk Management at (402) 471-2551

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The following pages explain the various sections of the Miscellaneous Claim Form. The title of each section is provided, followed by a description and an explanation of the information requested. Please note that when a field contains an asterisk (*), it is a **REQUIRED FIELD** and cannot be left blank. Please fill out the fields with the asterisks completely. This will help the investigation.

Claimant's Name*:

This is the name of the person making the claim. If the claim were to be approved, this is also the person who will be paid. This name is the same as the Claimant's signature.

Claimant's Phone Number *:

This is the phone number of the Claimant, the number where the Claimant can be reached during the day.

Alternate Phone Number:

This is any other phone number than the daytime phone number listed above. This field may be left blank when there is no alternate phone number.

Claimant's Mailing Address *:

This is the mailing address of the Claimant. The Office of Risk Management will send correspondence to the Claimant at this address.

Claimant's Email Address:

Does the Claimant have an email address? If so, please list the email address here. This is not a required field. This space may be left blank if there is no email address.

Is Claim Work Related?:

If the Claimant is employed by the State of Nebraska, and this claim is related to the Claimant's work, answer yes. If this claim is not work-related, answer no.

Is Claimant a State Employee?:

Is the Claimant employed by the State of Nebraska? If so, select YES. If the Claimant is not an employee of the State of Nebraska, select NO.

If Yes, What Is Agency Name?:

If the Claimant is an employee of the State of Nebraska and this claim is work-related, in what State agency is the Claimant employed?

Is Claimant Medicare Eligible? *:

If the Claimant is Medicare eligible, select YES. If not, select NO.

Date of Occurrence *:

This is the date that the incident listed on the claim occurred. When did the loss occur? When did the incident happen?

Total Amount of Claim *:

This is the total dollar amount the Claimant is seeking to replace the cost of this claim's alleged loss. This figure includes all payments made that cover the alleged loss the Claimant has experienced.

Place of Occurrence:

Where did this incident occur? This is not a required field, but this information will help the investigation of the claim.

Do You Have Insurance Covering This Claim?:

Is there an insurance company that has investigated this claim? If so, select YES.

Deductible:

What is the deductible as deemed by the Claimant's insurance policy?

Name and Address of Insurance Company & Insurance Policy Number:

What is the name of the Claimant's insurance company? What is the mailing address of the Claimant's insurance company? Please list this information here.
What is the number of the Claimant's insurance policy? Please list this information here.

Name, Address, and Phone Number of Attorney, if any:

If the Claimant is represented by an attorney, list the name and mailing address of the attorney.

Itemization of All Known Facts/Circumstances/Damages Leading to Your Claim *:

In the space provided, please list a detailed itemization of all known facts, circumstances, or damages leading to this claim. Identify all property, places, and people involved. Include names, addresses, and phone numbers of witnesses, if any.

Attach additional paper, if needed, to complete this field. This is an important field that describes in detail the circumstances of the event that lead to the claim. This information will help the investigation.

The information provided herein, along with the findings of the investigating agency, will form the basis of any decision. Investigation of this claim can take up to six months, and may take longer in some circumstances.

Claimant Signature*:

This is the Claimant's signature. Claims cannot be processed without the Claimant's signature.

Date*:

This is the date that the Claimant is signing the form. Claims cannot be processed without the date of signature.

Only completed and signed Claim Forms will be accepted. Please retain copies of all enclosed documents, including this claim form.

Claimant must provide the necessary documentation to substantiate their claim. Examples of documents to submit include, but are not limited to, Photos, Invoices, Receipts, Police Reports, Estimates, Medical Bills, Expense Reports, etc. Do not send originals; **send copies only**. This information will help the investigation of the claim.

Once the Claim Form has been completed it needs to be submitted to the Office of Risk Management. It is recommended that the form be submitted electronically, however it can also be submitted by mail, fax, or in-person.

To Submit Your Claim Electronically:

Please email the completed, signed, and dated form as well as any supporting documents to:

as.riskmanagement@nebraska.gov

If submitting electronically, keep in mind that a typed signature is legally binding and equivalent to a handwritten signature.

To Submit Your Claim by Mail:

Please mail the completed, signed, and dated form as well as any supporting documents to:

Office of Risk Management
PO Box 94974
Lincoln, NE 68509-4974

To Submit Your Claim by Fax:

Please fax the completed, signed, and dated form as well as any supporting documents to:

402-471-2800

To Submit Your Claim in Person:

Please bring the completed, signed, and dated form as well as any supporting documents to:

Office of Risk Management
1526 K Street, Suite 220
Lincoln, NE 68508

What Happens Next?

Claims under $5,000.00:

Once filed, a letter of acknowledgement confirming that the claim has been received will be mailed to the Claimant and the appropriate agency will be notified. After the investigation is complete, the Risk Manager will then approve or deny the claim, based upon the available information.

If approved, a release will be sent to the Claimant. The original release needs to be signed, in the presence of a public notary, and returned to the Office of Risk Management exactly as instructed in the accompanying letter. Once the signed and notarized release has been received, the claim will be processed for payment.

The acceptance by the Claimant of award shall be final and conclusive on the Claimant's part. Acceptance shall constitute a complete release by the Claimant

of any claim against the State or against the employee of the State whose act or omission gave rise to the claim.

If denied, a denial letter will be sent to the Claimant and the claim will be closed.

If a Claimant is dissatisfied with the Risk Manager's decision, whether approved or denied, a request that the State Claims Board review the claim may be submitted. A request for appeal, submitted in writing, is required to be sent to the Office of Risk Management within 60 days of the date on the Risk Manager's approval or denial letter. The claim will then be heard by the State Claims Board (please see below).

Claims $5,000.00 to $50,000.00 and Appeals (State Claims Board):

Appealed claims and those ranging from $5,000.00 to $50,000.00 must be approved or denied by the State Claims Board. Claimants will be notified by mail of the hearing date and time. The hearing dates are posted in the Office of Risk Management and also under the State Claims Board tab at the Office of Risk Management website. Claimants may attend the hearing, but it is not required. If a Claimant wishes to attend, they must notify the Office of Risk Management, in writing, at least one week prior to the hearing. Once the claim has been heard by the State Claims Board, the Claimant will be notified of the action taken on the claim within ten days of the hearing.

If a Claimant is dissatisfied with the decision of the board, they may file an application for review by the Legislature. The application for review must be filed with Risk Management within sixty days after the date of the State Claims Board decision.

Claims above $50,000.00:

Claims recommended for approval that are above $50,000.00 must be approved by the Nebraska State Legislature. The Legislature meets once per year, beginning in January. If approved by the Nebraska State Legislature, the signature of the Governor of Nebraska is required in order to process the claim for payment.

State Claims Board Hearings:

The State Claims Board shall have the power and authority to receive, investigate, and otherwise carry out its duties with regard to:

- All claims under the State Tort Claims Act, Nebraska Revised Statutes §§ 81-8,209 to 81-8,235.
- All claims under the State Miscellaneous Claims Act, Nebraska Revised Statutes §§ 81-8,294 to 81-8,301.
- All claims under Nebraska Revised Statutes §§ 25-1802 to 25-1807,
- All claims under the State Contract Claims Act, Nebraska Revised Statutes §§ 81-8,302 to 81-8,306,
- All requests on behalf of any department, board, or commission of the state for waiver or cancellation of money or charges when necessary for fiscal or accounting procedures, and
- All claims filed under section 66-1531. (See Nebraska Revised Statute §§ 81-8,297).

The Director of Insurance, Commissioner of Labor, and Director of Administrative Services shall constitute the State Claims Board which shall be part of the Risk Management Program created by section Nebraska Revised Statute § 81-8,239.01. The Attorney General shall be its legal advisor. (See Nebraska Revised Statute § 81-8,220)

The State Claims Board meets quarterly. The dates of the hearings are posted in Office of Risk Management and also under the State Claims Board tab at the Office of Risk Management website. The hearings are informal pursuant to the Open Meetings Act, Nebraska Revised Statutes §§ 84-1407 to 84-1414. The Claimant does not need to be present for the claim to be heard. Claims will be heard before the Nebraska Legislature once per year.

Please call the Office of Risk Management at (402) 471-2551, Monday – Friday, 8 AM to 5 PM, if there are any questions.

It is important to keep copies of all documentation submitted to the Office of Risk Management, State of Nebraska.