

## CLAIMS PROCEDURE

For persons wishing to file a claim against the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan (GCHP), a [General Claim Form](#)\* must be completed and submitted to the Clerk of the Commission.

GCHP is prohibited from providing you with legal advice. The California Government Code beginning with Section 900 concerns claims against public entities. Please note the following:

Claims relating to causes of action for death or injury to a person or damage to personal property or growing crops must be presented to the GCHP no later than six months after the incident date.

Claims relating to any cause of action other than those for death or injury to a person or damage to personal property must be presented no later than one year after the incident date (California Government Code Section 911.2).

Once claims are received by the Clerk of the Commission, claims are referred to the Commission's Legal Counsel. The Legal Counsel conducts an investigation into the information in your claim. Your claim form is generally your only opportunity to present information you wish GCHP to consider. The Legal Counsel makes a recommendation to the Commission based upon the information obtained and the laws of California.

The Commission must act within forty-five days after you submit your claim (California Government Code Section 911.6). If the Commission fails to act within forty-five days, the claim is deemed to have been denied as a matter of law (California Government Code Section 911.6).

**INSTRUCTIONS FOR FILING A CLAIM WITH VENTURA COUNTY MEDI-CAL  
MANAGED CARE COMMISSION doing business as GOLD COAST HEALTH PLAN**

The following provides specific instructions for completing each section of the Claim Form:

1. Name, Mailing Address and Telephone Number of Claimant(s).  
State full name, mailing address and telephone number of the person(s) claiming damage or injury.
  
2. Dollar Amount of Claim.  
State the total amount being claimed as a result of any alleged damage or injury. If damage or injury is continuing, or is anticipated in the future, indicate by writing a plus sign “(+)” following the dollar figure.
  
3. Official Notices and Correspondence.  
Provide the name and mailing address of the person to whom all correspondence should be sent, if other than the Claimant. This official contact person can be either the Claimant, or a representative of the Claimant.
  
4. When Did Damage / Injury Occur?  
State the exact month, day, year and time the incident occurred. Under state law, claims relating to causes of action for death or for injury to a Person or for damage to personal property or growing crops must be presented to GCHP no later than six months after the incident date.

If you are filing a claim beyond the six-month period, an *Application for Leave to Present a Late Claim* must also be included with your claim. An *Application for Leave to Present a Late Claim* is your written explanation of the reason(s) why the claim was not filed within the six-month period. In considering the claim, the GCHP will first decide whether or not the *Application for Leave to Present a Late Claim* should be granted or denied. (See Government Code Section 911.4 for the legally acceptable reasons a claim may be filed late.)

**ONLY IF LEAVE TO PRESENT A LATE CLAIM IS GRANTED, WILL THE GCHP CONSIDER THE MERITS OF THE CLAIM.**

Claims relating to any cause of action other than those for death or injury to a person, or for damage to personal property, must be presented no later than one year after the incident date. (GOVERNMENT CODE SECTIONS 911.2 and 911.4.)

5. Location of Incident.  
Include the city, county and street address of occurrence.

6. Presenting Facts on How Incident Occurred.

Provide in FULL detail the circumstances that led up to the incident. Identify ALL FACTS which support the claim. Include the name of the agency and / or employee that allegedly caused the damage / injury, as well as a specific identification as to any condition of public property that allegedly caused the incident.

7. Describing the Damage / Injury and How Amount of the Claim was Computed.

Provide in full detail a description of the damage / injury that allegedly resulted from the incident. Provide a breakdown of how the total amount that is being claimed was computed. Expenses incurred and / or future anticipated expenses may be declared. Attach to the claim copies of all bills, payment receipts, any photos of scene, damage, etc. **ANY CLAIMS FOR DAMAGE TO A VEHICLE MUST BE ACCOMPANIED BY TWO ESTIMATES AND PHOTO(S) OF DAMAGE.** If you need more space, please write on the back of the Claim Form or separate piece of paper.

8. Signature.

The Claim Form must be signed by the Claimant, or by the attorney or representative of the Claimant. GCHP will not accept the Claim without a proper signature. GOVERNMENT CODE SECTION 910.2 PROVIDES: "The claim must be signed by the claimant or some person on his / her behalf."

Provide all information you wish GCHP to consider. You will not be contacted for additional information. Please submit by personal delivery or mail the **original Claim Form** and supporting documentation to the Clerk of the Commission at the following address:

Gold Coast Health Plan  
Clerk of the Commission  
2220 E. Gonzales Road, Suite 200  
Oxnard, CA 93036

ANY CLAIM PRESENTED WITH INSUFFICIENT INFORMATION WILL BE RETURNED WITH NO ACTION TAKEN BY GCHP (GOVERNMENT CODE SECTIONS 910, 910.2, 910.4, and 910.8).

All claims will be investigated by GCHP and / or its Legal Counsel. State Law allows the Commission of GCHP 45 days to respond to your claim. You will be notified in writing of the Commission's action or inaction in 45 days.

**CLAIM Against the VENTURA COUNTY MEDI-CAL MANAGED CARE  
COMMISSION doing business as GOLD COAST HEALTH PLAN**

To: Clerk of the Commission  
Gold Coast Health Plan  
2220 E. Gonzales Road, Suite 200  
Oxnard, CA 93036  
(805) 889-6900

Pursuant to the provisions of Sections 905 and 920 of the Government Code of the State of California, demand is hereby made against Ventura County Medi-Cal Managed Care Commission dba Gold Coast Health Plan. In support of said claim, the following information is submitted.

1. Name, Mailing Address, Telephone Number of Claimant(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Dollar Amount of Claim: \_\_\_\_\_
3. Address to Which Official Notices and Correspondence are to be Mailed:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Date and Time Alleged Damage / Injury Occurred: \_\_\_\_\_
5. Location of Where Alleged Damage / Injury Occurred: \_\_\_\_\_  
\_\_\_\_\_
6. Facts on How Alleged Damage / Injury Occurred (Include Name of GCHP Employee(s) Who Caused Injury, if Known): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Describe Damage / Injury and How Amount of Claim was Computed:  
\_\_\_\_\_  
\_\_\_\_\_
8. \_\_\_\_\_  
Date  
Signature of Claimant  
(Person Acting on Claimant's Behalf)

NOTE: Provide all information you wish GCHP to consider and submit **original signed claim form** and back-up documentation if any, to address listed above. ANY CLAIM PRESENTED WITH INSUFFICIENT INFORMATION WILL BE RETURNED WITH NO ACTION TAKEN BY GCHP (GOVERNMENT CODE SECTIONS 910, 910.2, 910.4, AND 910.8).