

Board of Directors

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Administrative Assistant  
TOPYA OCEJ

Accountant/Controller  
TRISH WILKINSON

CLAIM AGAINST HIDDEN VALLEY LAKE  
COMMUNITY SERVICES DISTRICT  
FORM

The undersigned hereby presents the following claim against Hidden Valley Lake Community Services District (HVLCSO) in accordance with the provisions of Government Code section 910.

NAME OF CLAIMANT: \_\_\_\_\_

ADDRESS OF CLAIMANT: \_\_\_\_\_

Are you over 18 years of age? \_\_\_\_\_ Yes \_\_\_\_\_ No

Mailing address to which notices from HVLCSO are to be directed:

\_\_\_\_\_  
\_\_\_\_\_

DATE OF INCIDENT: \_\_\_\_\_ TIME OF INCIDENT \_\_\_\_\_

Date when incident, damages or losses were discovered: \_\_\_\_\_

LOCATION OF INCIDENT: \_\_\_\_\_

\_\_\_\_\_

1. How or under what circumstances did damages or injury occur? Please describe the particular occurrence, incident, act or omission you claim caused damage or injury.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What are the names of HVLCSD's employee(s) who you claim caused the incident and related damages, injuries, or loss?

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3. Please provide a general description of the indebtedness, obligation, injury, damage, or loss of which you are aware at this time.

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4. Is the dollar amount of the claim, including the estimate of any prospective injury, loss or damage in excess of \$10,000? \_\_\_\_\_ Yes \_\_\_\_\_ No

5. If you answered "No" above, please provide the dollar amount of the claim and the basis of its computation. Please attach pages to this claim form as necessary. \$ \_\_\_\_\_

6. If you answered "Yes" above, do not provide the amount of your claim. Instead, only indicate whether the claim will be a limited civil case within the meaning of the Code of Civil Procedures section 85.

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Signature of Claimant

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Date

If signed by a person under 18 years of age, the form must be countersigned by the parent or legal guardian of the minor.

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Print name of Parent/Legal Guardian

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Signature of Parent/Legal Guardian

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Date

If signed by a representative:

Representative's Name: \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Relationship of Claimant: \_\_\_\_\_