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**FILING A CLAIM AGAINST THE
TRANSIT JOINT POWERS AUTHORITY FOR MERCED COUNTY**

Transit **J**oint **P**owers **A**uthority
For **M**erced **C**ounty

Claims Must be Filed at the Following Location:

Transit Joint Powers Authority for Merced County
369 W. 18th Street
Merced, CA 95340

You must file your claim form, by mail or in person, with the Clerk of the Transit Joint Powers Authority for Merced County, 369 W. 18th Street, Merced, CA 95340, **within the time prescribed by Government Code section 911.2**, which states, “A claim relating to a cause of action for death or for injury to person or to personal property or growing crops shall be presented as provided in Article 2 (commencing with Section 915) of this chapter not later than six months after the accrual of the cause of action. A claim relating to any other cause of action shall be presented as provided in Article 2 (commencing with Section 915) of this chapter not later than one year after the accrual of the cause of action.”

Transit Joint Powers Authority For Merced County

You may file in person or mail form to: Clerk, Transit Joint Powers Authority for Merced County, 369 W. 18th St., Merced, CA 95340. [Print/Type Only.] Please provide two (2) copies of the claim. If you are mailing the claim, also include a stamped, self-addressed envelope for the return of a copy to you. Claims will be stamped and numbered by the Clerk of the Transit Joint Powers Authority for Merced County, and one copy will be returned to claimant for claimant's records.

**CLAIM AGAINST THE TRANSIT
JOINT POWERS AUTHORITY
FOR MERCED COUNTY**

Claim Number (Dept. Use Only)

1. Claimant's Name:

Date of Birth:

Last First Middle

2. Claimant's Address:

Street (or P.O. Box) City State Zip Code

3. Address Where Correspondence Should be Sent (if different from above):

Street (or P.O. Box) City State Zip Code

4. Phone Number: () _____ () _____ () _____

5. Amount of Claim: \$ _____

6. Date of Accident/Incident/Loss: _____

7. Location of Accident/Incident/Loss: _____

8. Provide Your Description of How the Accident/Incident/Loss Occurred:

9. Describe Damage/Injury/Losses Being Claimed (including prospective damage/injury/losses to the extent known at the time of claim filing):

10. Name(s) of Public Entity/Employee(s) Causing Injury/Damage/Loss:

11. Names and Addresses of any and all Witnesses Known:

12. If You are Claiming You Sustained an Injury, Please Provide the Names and Addresses of any and all Medical Professionals who Treated or are Treating You for Those Claimed Injuries:

13. Itemized List of Claimed Expenses/Damages (should equal line 5):

Item:	Dollar Amount:
_____	\$ _____
_____	\$ _____
(Please Attach any Estimates* And/or Receipts to Your Claim)	\$ _____
TOTAL CLAIM:	\$ _____

Do Not Write in This Space

*1 Estimate if Repairs are less than \$1,000
*2 Estimates if Repairs are more than \$1,000

14. Date:

Signature of Claimant/Representative:

You Must Present Your Claim Within the Time Prescribed by Govt. Code section 911.2.