

**OFFICE OF CLAIMS AND APPEALS  
BOARD OF CLAIMS  
500 Mero Street, 2SC1, Frankfort, Kentucky, 40601, 502-782-8255**

**CLAIM FORM GENERAL INSTRUCTIONS**

**You must use ink or type the information. Although no filing fee is charged, the signed claim form with all evidence attached is required. If an attorney is involved, the Claimant and the attorney must sign the claim form. KRS 49.180 states no claim shall be brought before the Board unless the total amount of damages claimed is \$250 or greater. The maximum award shall not exceed a single individual award of \$250,000 and multiple claims shall not exceed a total award of \$400,000 for a single act of negligence.**

Section I. Information about the claimant only.

Section II Name of the State agency involved.

Section III. The name of the person that referred you to the Board of Claims.

Section IV. Date and time of the incident. Must generally be filed within one year.

Section V. Provide incident information. **Be specific.**

Section VI. Give a complete incident description.

Section VII Describe completely how the state agency or employee was at fault.

Section VIII. State the exact dollar amount of your claim and include itemized receipt(s), OR at least one (1) repair estimate for damages.

Section IX. Complete this section if a motor vehicle was involved, with a copy of the police report, if any. **You must submit verification of the amount of your deductibles on your car insurance policy, i.e., either insurance declaration page or insurance card if the deductibles are listed on it.**

Personal Injuries must be supported with proper documentation, insurance policy numbers, effective dates, etc. Other damage must be supported with proper insurance information, policy number, effective dates, and deductible(s).

The Board of Claims accepts claim forms by mail, fax, email, or via online portal.

**No awards can be granted for the following:**

- Claims under \$250.
- Claims for pain and suffering.
- Collateral, dependent or subrogation claims.
- Claims where the Board has no jurisdiction (i.e., areas or events where legal responsibility lies with contracted entities or non-state agencies).

**YOU MUST SIGN as the claimant and you MUST provide your Social Security or Federal ID before your claim can be investigated or submitted for a hearing.**

500 Mero Street 2SC1  
Frankfort, KY 40601  
Telephone: (502) 782-8255  
Fax: (502) 573-4817  
Email: [negligenceclaims@ky.gov](mailto:negligenceclaims@ky.gov)

**COMPLETE ALL SECTIONS THAT APPLY TO YOUR SPECIFIC CLAIM**

Claims for damages must be at least two hundred fifty dollars (\$250.00). An original or a copy of the form may be delivered for filing by mail, fax, email, or online portal.

V. \_\_\_\_\_ \*\* County  
Location where the incident occurred. Please provide **exact** location including **direction (North, South, East or West), mile marker, name or number of road, intersection,** etc. **PLEASE BE SPECIFIC** so that your claim may be thoroughly investigated.

VI. Describe the incident and the damage done to you or your property.

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VII. In what way do you believe the state agency or employee was at fault? What more could the state have done?

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VIII. State the specific dollar amount of your claim. \$ \_\_\_\_\_  
Submit bills, receipts and/or **ONE** repair estimate as proof of the cost of damages sustained.

**Pursuant to KRS 49.130, this amount will be amended according to the amount you have a right to receive from your insurance, regardless of whether you file a claim with your insurance company.**

IX. If motor vehicles were involved, please complete the following:

**STATE VEHICLE:**

Tag number, if known \_\_\_\_\_

Driver, if known \_\_\_\_\_

**CLAIMANT'S VEHICLE: (This claim must be filed and signed by the registered owner)**

In whose name is the vehicle registered? \_\_\_\_\_

Vehicle year, make and model: \_\_\_\_\_

Name and address of driver and passengers:

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Name of law enforcement authority or officer who investigated the incident: \_\_\_\_\_

**Please submit a copy of police report, incident report, or Uniform Traffic Report if possible.**

Pursuant to KRS 49.130, the Board can only award what you cannot recover through insurance or any other source. The Board **must reduce** any award by the amount you have a right to receive from any insurance coverage, even if no claim was filed with your insurance company. In order to review your claim as submitted, provide all information below that relates to the damages you incurred.

### VEHICLE INSURANCE

**You must submit your insurance declaration page  
OR insurance card if the deductibles are listed on the card**

1) Insurance Agent and Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

2) Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Effective Dates: \_\_\_\_\_

3) Collision Coverage in Effect: ( ) Yes ( ) No      Amount of Deductible \$ \_\_\_\_\_

4) Comprehensive Coverage in Effect: ( ) Yes ( ) No      Amount of Deductible \$ \_\_\_\_\_

5) Liability Coverage only: ( ) Yes ( ) No

### PERSONAL INJURY INSURANCE

(complete this section only if you are making a claim for personal injury)

6) Hospitalization Insurance in Effect: ( ) Yes ( ) No      Dental Insurance in Effect: ( ) Yes ( ) No

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Effective Dates: \_\_\_\_\_

Amount of Deductible: \_\_\_\_\_ Has this deductible been met for the year? ( ) Yes ( ) No

7) Compensation Insurance Coverage in Effect: ( ) Yes ( ) No

Name of Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Effective Dates: \_\_\_\_\_

Deductible: \_\_\_\_\_ Has this deductible been met yet for this year? ( ) Yes ( ) No

8) If you have ***any other insurance coverage*** that would entitle you to recover the damages, which are the subject of your claim, please list what type and the amount of the deductible if any.

\_\_\_\_\_

## OTHER INSURANCE

9) Homeowner \_\_\_\_\_ Dwelling \_\_\_\_\_ or Mobile Home Coverage \_\_\_\_\_

Name of Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Effective Dates: \_\_\_\_\_

Deductible: \_\_\_\_\_ Has this deductible been met yet this year? ( ) Yes ( ) No

10) If you have any other insurance coverage that would entitle you to recover the damages, which are the subject of your claim, please list what type and the amount of the deductible if any.

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**YOU MUST SIGN :** Claimant's Signature: \_\_\_\_\_

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

Daytime Telephone: \_\_\_\_\_ (work) Telephone: \_\_\_\_\_

Mobile Telephone: \_\_\_\_\_

Date: \_\_\_\_\_

**WE MUST HAVE:** Social Security Number or Federal ID Number: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_

Attorney's Signature: \_\_\_\_\_

*(if represented by Counsel)*

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

Telephone: \_\_\_\_\_ Date: \_\_\_\_\_

Federal ID Number: \_\_\_\_\_

Pursuant to KRS 49.120, claims generally must be presented to the Board of Claims within one (1) year from the date of the incident. There are exceptions for personal injury and for medical malpractice claims.

Commonwealth of Kentucky  
Public Protection Cabinet  
Office of Claims & Appeals  
kycc.ky.gov  
Revised 1-2025



**CIVIL**  
☐ SUBPOENA  
☐ SUBPOENA DUCES TECUM

Case No. \_\_\_\_\_  
Board of Claims

\_\_\_\_\_  
VS  
\_\_\_\_\_

CLAIMANT

RESPONDENT

**Pursuant to KRS 49.020(7)(b), and the authority granted therein:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

**You are to appear at:** \_\_\_\_\_  
\_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_ at \_\_\_\_\_ ☐ a.m. OR ☐ p.m. ☐ Eastern ☐ Central Time

☐ To testify in behalf of \_\_\_\_\_  
☐ To produce \_\_\_\_\_

☐ To give depositions

**You are commanded to produce and permit inspection and copying of the following documents or objects (or to permit inspection of premises):** \_\_\_\_\_  
\_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_ at \_\_\_\_\_ ☐ a.m. OR ☐ p.m. ☐ Eastern ☐ Central Time  
at the following address: \_\_\_\_\_

_____ Issuing Officer
By: _____

_____ Name of Requesting Attorney/Pro-Se Party
_____ Address
Phone # _____
E-mail: _____

**PROOF OF SERVICE**

This subpoena was served by delivery of a true copy to: _____	
This _____ day of _____, 2____	By: _____
	_____ Title

**Print Form**

**Reset Form**

**INSTRUCTIONS TO AGENCY:** Send a copy of this answer within 30 days to the claimant and a copy to the Board of Claims. KRS 49.090 requires agency answers to be factual and specific.

Claim No: \_\_\_\_\_

Name of Claimant: \_\_\_\_\_

Name of State Agency: \_\_\_\_\_

Date of Answer: \_\_\_\_\_

### **Agency's Answer To Claimant and Board of Claims**

\_\_\_\_\_ 1. This agency has investigated this claim, and I recommend that the Board order that \$\_\_\_\_\_ be paid to the claimant. The claimant has stated the pertinent facts correctly. The damage claimed was caused by negligence on the part of this agency or its employee(s).

\_\_\_\_\_ 2. This agency has investigated this claim. I recommend that the claim not be paid and that the Board dismiss the claim. The facts of the incident are substantially as stated by the claimant, but the damage that occurred was not caused by negligence on the part of the State, this agency, or any State employee. Instead, our investigation shows that the damage was caused by:

\_\_\_\_\_ 3. This agency has investigated this claim. I recommend that the claim not be paid and that the Board dismiss the claim. Our investigation finds that whatever damage the claimant may have sustained in the incident was due to negligence on the part of the claimant. The negligence on the claimant's part was:

\_\_\_\_\_ 4. This agency has investigated this claim. I recommend that the claim not be paid and that the Board dismiss the claim. Our agency's investigation shows that the facts are substantially not as stated by the claimant but, instead, are as follows:

\_\_\_\_\_ 5. This agency has made every reasonable effort to investigate this claim but we are unable to do so. Here are the efforts we have made, and here is what prevents us from finding out about this claim:

\_\_\_\_\_ 6. Other (Be factual):

***I certify that the original of the foregoing Agency's Answer To Claimant and Board of Claims has been filed with the Board of Claims, 500 Mero St., 2SC1, Frankfort, KY 40601 and a copy hereof was served this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ on the following:***

**Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

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

**Attach Additional pages if needed.**