Excerpt from Chapter 768.28, Florida Statutes

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(1) In accordance with s. 13, Art. X of the State Constitution, the state, for itself and for its agencies or subdivisions, hereby waives sovereign immunity for liability for torts, but only to the extent specified in this act. Actions at law against the state or any of its agencies or subdivisions to recover damages in tort for money damages against the state or its agencies or subdivisions for injury or loss of property, personal injury, or death caused by the negligent or wrongful act or omission of any employee of the agency or subdivision while acting within the scope of the employee's office or employment under circumstances in which the state or such agency or subdivision, if a private person, would be liable to the claimant, in accordance with the general laws of this state, may be prosecuted subject to the limitations specified in this act. Any such action may be brought in the county where the property in litigation is located or, if the affected agency or subdivision has an office in such county for the transaction of its customary business, where the cause of action accrued. However, any such action against a state university board of trustees shall be brought in the county in which that university's main campus is located or in the county in which the cause of action accrued if the university maintains therein a substantial presence for the transaction of its customary business.

(2) As used in this act, "state agencies or subdivisions" include the executive departments, the Legislature, the judicial branch (including public defenders), and the independent establishments of the state, including state university boards of trustees; counties and municipalities; and corporations primarily acting as instrumentalities or agencies of the state, counties, or municipalities, including the Florida Space Authority.

(3) Except for a municipality and the Florida Space Authority, the affected agency or subdivision may, at its discretion, request the assistance of the Department of Financial Services in the consideration, adjustment, and settlement of any claim under this act.

(4) Subject to the provisions of this section, any state agency or subdivision shall have the right to appeal any award, compromise, settlement, or determination to the court of appropriate jurisdiction.

(5) The state and its agencies and subdivisions shall be liable for tort claims in the same manner and to the same extent as a private individual under like circumstances, but liability shall not include punitive damages or interest for the period before judgment. Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000. However, a judgment or judgments may be claimed and rendered in excess of these amounts and may be settled and paid pursuant to this act up to $200,000 or $300,000, as the case may be; and that portion of the judgment that exceeds these amounts may be reported to the Legislature, but may be paid in part or in whole only by further act of the Legislature. Notwithstanding the limited waiver of sovereign immunity provided herein, the state or an agency or subdivision thereof may agree, within the limits of insurance coverage provided, to settle a claim made or a judgment rendered against it without further action by the Legislature, but the state or agency or subdivision thereof shall not be deemed to have waived any defense of sovereign immunity or to have increased the limits of its liability as a result of its obtaining insurance coverage for tortious acts in excess of the $200,000 or $300,000 waiver provided above. The limitations of liability set forth in this subsection shall apply to the state and its agencies and subdivisions whether or not the state or its agencies or subdivisions possessed sovereign immunity before July 1, 1974.

(6)(a) An action may not be instituted on a claim against the state or one of its agencies or subdivisions unless the claimant presents the claim in writing to the appropriate agency, and also, except as to any claim against a municipality or the Florida Space Authority, presents such claim in writing to the Department of Financial Services, within 3 years after such claim accrues and the Department of Financial Services or the appropriate agency denies the claim in writing; except that, if:

1. Such claim is for contribution pursuant to s. 768.31, it must be so presented within 6 months after the judgment against the tortfeasor seeking contribution has become final by lapse of time for appeal or after appellate review or, if there is no such judgment, within 6 months after the tortfeasor seeking contribution has either discharged the common liability by payment or agreed, while the action is pending against her or him, to discharge the common liability; or

2. Such action is for wrongful death, the claimant must present the claim in writing to the Department of Financial Services within 2 years after the claim accrues.

(b) For purposes of this section, the requirements of notice to the agency and denial of the claim pursuant to paragraph (a) are conditions precedent to maintaining an action but shall not be deemed to be elements of the cause of action and shall not affect the date on which the cause of action accrues.

(c) The claimant shall also provide to the agency the claimant's date and place of birth and social security number if the claimant is an individual, or a federal identification number if the claimant is not an individual. The claimant shall also state the case style, tribunal, the nature and amount of all adjudicated penalties, fines, fees, victim restitution fund, and other judgments in excess of $200, whether imposed by a civil, criminal, or administrative tribunal, owed by the claimant to the state, its agency, officer or subdivision. If there exists no prior adjudicated unpaid claim in excess of $200, the claimant shall so state.

(d) For purposes of this section, complete, accurate, and timely compliance with the requirements of paragraph (c) shall occur prior to settlement payment, close of discovery or commencement of trial, whichever is sooner; provided the ability to plead setoff is not precluded by the delay. This setoff shall apply only against that part of the settlement or judgment payable to the claimant, minus claimant's reasonable attorney's fees and costs. Incomplete or inaccurate disclosure of unpaid adjudicated claims due the state, its agency, officer, or subdivision, may be excused by the court upon a showing by the preponderance of the evidence of the claimant's lack of knowledge of an adjudicated claim and reasonable inquiry by, or on behalf of, the claimant to obtain the information from public records. Unless the appropriate agency had actual notice of the information required to be disclosed by paragraph (c) in time to assert a setoff, an unexcused failure to disclose shall, upon hearing and order of court, cause the claimant to be liable for double the original undisclosed judgment and, upon further motion, the court shall enter judgment for the agency in that amount. Except as provided otherwise in this subsection, the failure of the Department of Financial Services or the appropriate agency to make final disposition of a claim within 6 months after it is filed shall be deemed a final denial of the claim for purposes of this section. For purposes of this subsection, in medical malpractice actions and in wrongful death actions, the failure of the Department of Financial Services or the appropriate agency to make final disposition of a claim within 90 days after it is filed shall be deemed a final denial of the claim. The statute of limitations for medical malpractice actions and wrongful death actions is tolled for the period of time taken by the Department of Financial Services or the appropriate agency to deny the claim. The provisions of this subsection do not apply to such claims as may be asserted by counterclaim pursuant to s. 768.14.

(7) In actions brought pursuant to this section, process shall be served upon the head of the agency concerned and also, except as to a defendant municipality or the Florida Space Authority, upon the Department of Financial Services; and the department or the agency concerned shall have 30 days within which to plead thereto.

(8) No attorney may charge, demand, receive, or collect, for services rendered, fees in excess of 25 percent of any judgment or settlement.

(9)(a) No officer, employee, or agent of the state or of any of its subdivisions shall be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. However, such officer, employee, or agent shall be considered an adverse witness in a tort action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. The exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state or any of its subdivisions or constitutional officers shall be by action against the governmental entity, or the head of such entity in her or his official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless such act or omission was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. The state or its subdivisions shall not be liable in tort for the acts or omissions of an officer, employee, or agent committed while acting outside the course and scope of her or his employment or committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee or agent" includes, but is not limited to, any health care provider when providing services pursuant to s.766.1115; any nonprofit independent college or university located and chartered in this state which owns or operates an accredited medical school, and its employees or agents, when providing patient services pursuant to paragraph (10)(f); and any public defender or her or his employee or agent, including among others, an assistant public defender and investigator.

Appendix B

VOLUNTEER HEALTH CARE PROVIDER PROGRAM
PATIENT REFERRAL FORM

Referral #

NOTICE TO PATIENT

You are being referred to a volunteer health care provider who will provide free care to you or someone for whom you are legally responsible. Depending on the determination of the volunteer health care provider, you may also receive services from pathologists, laboratories, radiologists, and anesthesiologists. Your participation in this referral process is voluntary. The care you receive from the volunteer health care professionals will be provided at no charge to you. However, you may be billed for pharmaceuticals. The health care providers are providing care on behalf of the State of Florida and each serves as an agent of the State. By acceptance of this referral, you acknowledge that the state solely is liable for any injury or damage suffered by you, or someone that you permit to receive treatment, that results from authorized treatment by the volunteer providers and that the State's liability is limited as found in section 768.28, Florida Statutes (copy provided)

I hereby certify that I have read the above notice and understand that I am being referred to a volunteer health care provider who will provide free care for me or someone for whom I am legally responsible. I further understand the volunteer health care provider may also refer me to pathologists, laboratories, radiologists, and anesthesiologists whose specialized services may be needed to treat my health condition. I authorize examination, diagnostic procedures and treatment as deemed necessary by the doctor(s) or other health care professional(s) (and income information, is true and complete to the best of my knowledge.

I also acknowledge I am responsible to inform the clinic of any change in my financial or health insurance status.

Signature: _____ Date: _____

If treatment is for a minor, indicate relationship to child

Patient's Name: _____ Date of Birth: _____

Address: _____ Sex: Male Female

City State Zip _____ Race: White Black Asian/PI Am Indian/Alaskan Native

Phone: _____ Ethnicity: Hispanic Non-Hispanic

Eligibility: (check one) DOH client/patient 200% poverty or less Medicaid eligible (no provider available)

Referral Type: Medical Care Dental Care Other (specify)

Notes: _____

_____

_____
Print Name of DOH Referring Person

_____ _____
DOH Referring Person's Signature Date

Referred to: _____

Address/Phone: _____ _____

As needed, the above-named health care provider is referring this patient to the following health care providers who are under contract as outlined in section 766.1115, Florida Statutes, and are agents of the state:

Pathologist Laboratory Radiologist Anesthesiologist

Response to Referral Originator: _____ Date of Initial Service Received _____
(actual services provided)

Estimated Value of Health Care Provided $

_____ _____
Volunteer Health Care Provider Signature Date

☐ In lieu of signature, see progress notes.

VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER: UNITED MEDICAL AND SOCIAL SERVICES (CLINIC)

Section 1

Does the client/patient have insurance that covers the health or dental condition? YES _____NO_**X**_ _____

Does anyone in the client/patient's family have an active FL Medicaid card? YES ____ NO **X**____

Name of the card holder and Medicaid No. _____

Client/Patient/Head of Household's Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

Section 2

Family Size: Adults____ Under 18 ____ 18-21--Student ____ Unborn _____ Family Size TOTAL _____

FAMILY MEMBERS NAME (First and Last)	**DOB**	**EMPLOYER**	**GROSS EARNED INCOME LAST 4 WKS**	**GROSS UNEARNED INCOME LAST 4 WKS (Do not include TCA or SSI)**
SELF			$	$
SPOUSE/PARTNER			$	$
CHILD			$	$
CHILD			$	$
CHILD			$	$
CHILD			$	$
		TOTALS	$	$
		Add earned and unearned income to determine total		**TOTAL INCOME** $ _____

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

Step 1. **"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income). (1) $ _____ (Above)

Step 2. Subtract $90 for EACH employed member of the family unit. (2) $ _____ (Minus)
(2a) $ _____ (Total)

Step 3. Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2). (3) $ _____ (Minus)
(3a) $ _____ (Total)

Step 4. Subtract up to $50 per month of total child support received. (4) $ _____ (Minus)

Step 5. **TOTAL NET INCOME** (5) $ _____ (Total)

Section 4 USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

_____ _____

SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN AND DATE

PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE

(VALID FOR ONE YEAR) Expiration date: _____

UMSS
your health matters

AUTHORIZATION to use or disclose Protected Health Information via Email or Other Electronic media

I hereby authorize **United Medical and Social Services Clinic**, and its entities, its officers, its volunteer or agents to communicate with me and other health care providers as necessary for my / patient's health care treatment via Email, Fax, copying, permit inspection, and/or release of information compiled in the ordinary course of business in connection with the following:

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____

Gender: _____ Marital Status: _____ Race: _____ Ethnicity: _____

Email: _____ Phone: _____ Language: _____

Contact Preference: **Home Phone / Work Phone / Mobile Phone / Portal / Email**

How did you hear about UMSS: _____ **If referred by Hospital:** _____

I understand that my **complete protected health information** may be used, disclosed, and retained by the healthcare providers as a result of the communications.

I further authorize the disclosure of the following information which may be included in the protected health information UNLESS EXPRESSLY EXCLUDED BY CHECKING THE BOX (ES) : Mental Health Substance Abuse HIV / AIDS

This information is to be disclosed to: _____

I have read and understand the Alert for Electronic Communications and agree that e-mail messages may include protected health information about me / the patient whenever necessary.

My Signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein:

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked in writing, this authorization will expire 1 year from the date of execution. A photocopy or FAX of this document is valid as the original.

Signature of Patient or Legal Representative: _____ Date: _____

Witness: _____ Date: _____

The patient information requested above may not be further disclosed to any party under any circumstances except with the patient's express written consent or as otherwise permitted by law. The information may not be used except for the need specified above.

LIABILITY WAIVER: This liability waiver is a **LEGAL DOCUMENT**. This liability waiver is a "catch all". By signing this waiver, you or your representative acknowledge that you or your representative WILL NOT seek civil or federal penalties or compensation in any court in the event of injury or death incurred while in the facility/facility premises against the aforementioned owner / tenant of the facility.

To the best of my knowledge the above information is complete and accurate.

Signed_____ Date: _____

ACKNOWLEDGEMENT AND AUTHORIZATION:

☐ I have read and understand the HIPAA/Privacy Policy for **United Medical and Social Services Clinic**

Signed _____ Date:_____

☐ I authorize **United Medical and Social Services Clinic** to obtain/have access to my medication history

Signed _____ Date:_____

☐ I authorize my provider's office to contact me by mobile phone

Signed _____ Date:_____

UMSS
your health matters

PATIENT INTAKE AND FINANCIAL ELIGIBILITY FORM

Last Name:	Middle Name:	First Name:	New Patient
			YES / NO

Date of Birth:	Insured:	Male Female	Age:
	YES / NO		

Address:

Street:

City:	State:	Zip:	Patients Relationship to Guarantor:
			Self / Spouse / Child / Grandchild / Other

E-Mail:	Phone:	Language:

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Race:

☐ African American ☐ Asian ☐ White ☐ Hispanic ☐ Native American ☐ Other

Ethnicity

☐ Hispanic ☐ Non-Hispanic ☐ Other

If you were referred by a Hospital? Check one:

☐ Central Florida Regional ☐ Orlando Health ☐ Advent Hospital ☐ Other

How did you hear about (UMSS)?

☐ Word of Mouth ☐ Television News ☐ Newspaper ☐ Hospital ☐ Other

Reason for Visit :

Family Size: **Adults____** **Under 18 ____** **18-21--Student ____** **Unborn _____** Family Size TOTAL _____

FAMILY MEMBERS NAME (First and Last)	**EMPLOYER**	GROSS EARNED INCOME LAST 4 WKS	GROSS UNEARNED INCOME LAST 4 WKS (Do not include TCA or SSI)
SELF		$	$
SPOUSE/PARTNER		$	$
CHILD		$	$
CHILD		$	$
CHILD		$	$
CHILD		$	$
	TOTALS	$	$

300% Monthly Income for 1 family member $3765

for each additional person add $1345 (2 people = $5110, 3 people = $6455)

Add earned and unearned income to determine total

TOTAL INCOME

$_____