Please Read Instructions on Reverse Side of Yellow copy

Please print in ink or type

Arkansas State Claims Commission MAY 17 2016

BEFORE THE STATE CLAIMS COMMISSION Of the State of Arkansas

ar.		RECEIVED
Mr. O Mrs.		Do Not Write in These Spaces
O Ms.		Claim No. 16-0752-CC
Donald Oswald and Kare		Date Filed May 17, 2016
vs.	his wife, Claimant	(MORU) (Day) (Year)
State of Arkansas, Respondent		Amount of Claim \$ 375,500.00
		Fund AHTD
rk: Highway Dept.		Property Damage (v) Personal Injury
	COMPLAI	NT Pain & Suffering
Donald and Karen Oswald,ti	he above named Claimant, of 2	
AR 72416	Craighead	(Street or R.F.D. & No.) (City)
(State) (Zip Code) (Daytime Phone No.)	County of	represented by Attorney Noyl Houston (Legal Counsel, if any, for Claim)
of PO Box 3076		2403 (870) 935-3730 (870) 935-0006
(Street and No.) State agency involved: _ Arkansas Highwa	(City) (State) (Zip iy and Transporta	Code) (Phone No.) (Fax No.) tion Department \$375,500.00
		Hwy. 63, Bono, Craighead County, A
Explanation:		The state of the s
herein for descrip	attached hereto tion of claim:	and incorporated by reference
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"ATTACHMENTS B-F"	TINDULUITO PI	ayments and documentation are atted by reference herein.
arso accadined her	eto and incorpora	ated by reference herein.
	·	
As parts of this complaint, the claimant makes the statements, a	nd answers the following questions, as	indicated: (1) Has claim been presented to any state department or officer thereof?
V	; to whom?	
(24)	(Year) he following action was taken thereon:	(Department)
	· · · · · · · · · · · · · · · · · · ·	
and that Swas paid thereon; (2) Has any third person or corporation a	un interest in this claim? NO. ; if so, state name and address
(Name) and that the nature thereof is as follows:	(Street or R.F.D. & No.)	(City) . (State) (Zip Code)
	: and was acquired on	2.41
		, in the following manner:
THE UNDERSIGNED states on oath that he or s	he is familiar with the matters and	things set forth in the above complaint, and that he or she verily believes
Donald Oswald	By:	AND KAREN OSWALD, CLAIMANTS
(Print Claimant/Representative Name)		louston, Attorney
Donald Oswald, Claimant	PO Box	3076, Jonesboro, AR 72403
Karensoad.	10 and subscribed	COLON
Karen Oswald, Claimant on the	his 13th day	of Y aw Only
	(Date)	0.4.4
GATE OFFICIAL SEAL - #12692133	\perp	SLAW TO () (MONIN) (Xear)
HOTARY LISA M. Westmoreland SELLE PUBLIC CRAIGHEAD COUNTY		(Notary Public)
EXPIRES: 11-18-2025 My	Commission Expires:	November 19, 2025
	,	(Month) (Day) (Year)

ATTACHMENT "A"

TO

Complaint of Claimants, Donald Oswald and Karen Oswald

FACTS

At approximately 5:59 p.m. on March 3, 2014, Donald Oswald ("Oswald") was southbound on U.S. Highway 63 enroute to the hospital because his mother-in-law had broken her hip. The highway was icy from sleet. An Arkansas Highway and Transportation Department ("AHTD") snowplow truck operated by Jeff Armstrong was northbound on Highway 63 traveling down "Bono Hill" at excessive speed, too fast for the conditions, lost control, and veered suddenly across the centerline, into the oncoming (southbound) lanes, hitting the small pickup operated by Oswald in the left rear quarter panel, causing it to spin violently, resulting in severe and permanent injuries to his neck, back, shoulder, arms and wrists as hereinafter described, as well as damage (total loss) to his pickup.

LIABILITY

As Armstrong was employed by AHTD (collectively, "AHTD"), and he was acting within the scope of his employment at the time of such collision, his negligence is imputed to AHTD.

AHTD is guilty of negligence which was the proximate cause of the collision described above and of the injuries and damages to Claimants, such negligence being hereinafter described in the following particulars:

- A. Driving at a speed that was greater than was reasonable and prudent under the circumstances;
- B. Failing to keep its truck under proper control;
- C. Failing to yield the right-of-way to the oncoming vehicle operated by Oswald;
- D. Improperly crossing the center line into the path of Oswald's vehicle;
- E. Operating its truck in violation of the following Arkansas statutes:
 - 1) A.C.A. 27-51-201 (Driving at a Speed Greater than is Reasonable and Prudent under Existing

Conditions);

- A.C.A. 27-51-501 (Driving Left of Center);
- 3) A.C.A. 27-51-104 (Careless and Prohibited Driving); and
- F. It was otherwise negligent.

PERSONAL INJURY

That as a direct and proximate result of the negligence of ATHD as described above, Oswald suffered severe and permanent injuries to his neck, back, shoulder, arms and wrists, including, but not limited to, the following:

- A. Cervical radiculopathy at C3-4 with cord compression resulting in neck pain radiating into his arms and hands requiring cervical discectomy with fusion at C3-C4, as well as bulging discs at C4-5 and C5-6;
- B. Either entrapment, or aggravation of previously asymptomatic entrapment, of median and ulnar nerves in Oswald's arms and wrists with resulting numbness requiring surgery on both wrists; and
- C. Aggravation of pre-existing low back condition with bulging disc at L4-L5, annular tear, and radiculopathy resulting in radiating low back pain into Oswald's buttocks and legs, among other things.

That in addition to the above injuries, Oswald has suffered permanent injury to his neck, back and upper extremities with residual consequences thereof; that Oswald has had considerable medical expenses to date, and he will have additional medical expense in the future with periodic therapy and analgesics; that Oswald has undergone tremendous pain, suffering and mental anguish, and he will undergo pain, suffering and mental anguish in the future, all to Oswald's damage in at least the sum of \$350,000.00, which should be awarded him from AHTD.

Additionally, Oswald's wife, Karen Oswald, has suffered a loss of consortium due to a partial loss of the services, society, companionship of her husband due to the severe and permanent injuries to him, and as a result of which she has suffered damages in the sum

of \$25,000.00, which should be awarded her from AHTD.

PROPERTY DAMAGE

That additionally, as the payment to Oswald by State Farm, his insurance carrier, for the total loss of his pickup proximately caused by the negligence of AHTD was reduced by the \$500.00 policy deductible, such \$500.00 deductible should be awarded him from AHTD.

EXHAUSTION OF REMEDIES

Oswald has exhausted his remedies against insurers, as follows:

- A. The AHTD driver, Jeff Armstrong, was excluded from coverage by policy language for operating his employer's vehicle. See letter dated August 7, 2014, of Safeco Insurance. Attached hereto as "Attachment B";
- B. Oswald had insurance on his pickup with State Farm Insurance Company (paid for by him) which paid him the following:
 - Comprehensive coverage on vehicle paid \$1,985.00 for the total loss of his truck (\$3,085.00 less \$500.00 deductible and \$600.00 for salvage). See letter dated April 29, 2016, from State Farm adjuster, Sartini Sounthavanh, attached hereto as "Attachment C".
 - 2. \$5,000.00 limit of medical payments coverage was exhausted. See letter dated April 11, 2014 and payments log from State Farm adjuster Melody Suthers attached hereto, collectively, as "Attachment "D".
 - 3. \$25,000.00 limit of uninsured motorist coverage was paid. See August 29, 2014, letter from St. Farm adjuster, Janice Shed, confirming \$25,000.00 UM limit offer with State Farm checks totaling \$25,000.00 attached hereto, collectively, as "Attachment E". From such proceeds Medicaid was reimbursed the \$9,032.37 in benefits paid, attorney's fees of \$8,333.33, and costs to date of \$351.46, were paid, leaving a reserve balance for additional costs and medical expenses of \$7,282.94.
- C. Arkansas Medicaid has paid \$9,032.37 toward Oswald's medical expenses. A copy of the September 4, 2014 and May 13, 2016

letters from Arkansas DHS with demand for \$5,641.78 in Medicaid payments, and an additional \$3,390.59 in Medicaid payments, respectively, with payment logs, are attached hereto, collectively, as "Attachment F". Medicaid payments are also shown on medical bills provided contemporaneously herewith.

Of the \$75,129.90 in medical expenses, \$14,896.99 in medical bills remain unpaid by insurance (St. Farm or Medicaid, including adjustments for Medicaid) as noted on the List of Medical Expenses filed contemporaneously herewith.

Claimants pray for recovery of their \$500.00 deductible for the total loss of their vehicle; Claimant Donald Oswald prays for \$350,000.00 for personal injury; and Claimant Karen Oswald prays for \$25,000.00 for loss of consortium.



Safeco Insurance Company of Illinois Safeco Insurance PO Box 515097 Los Angeles, CA 90051

Mailing Address: PO Box 515097 Los Angeles, CA 90051

Phone: (636) 326-8631 (888) 268-8840

August 7, 2014

Houston Law Firm Po Box 3076 Jonesboro, AR 72403

Insured Name:

Jeff Armstrong & Sherry Armstrong

Policy Number:

F2063313

Loss Date:

March 3, 2014

Claim Number:

551657665037

Your Client:

Don Oswald

·Dear Mr. Houston:

We want to let you know we have completed our investigation of Don Oswald's injury claim.

Under Mr. Armstrong's policy form SA-1852/AREP 5/11, coverage for liability is excluded since he was maintain or using a vehicle while employed or otherwise engaged in any business (trade, professions, or occupation. He is employed by the Arkansas Department of Transportation. and while clearing the ice and snow from the road while driving a vehicle owned by the DOT. Per Part A, Exclusions A.8:

- 8. Any insured maintaining or using any vehicle while that insured is employed or otherwise engaged in any business (other than farming or ranching) not described in exclusions A.6. or A.7. This exclusion (A.8.) does not apply to the maintenance or use of a:
 - a. private passenger auto;
 - b. pickup, motorhome or van that:
 - (1) you own; or
 - (2) you do not own while used as a temporary substitute for your covered auto which is out of normal use because of
 - (a) breakdown;
 - (b) repair;
 - (c) servicing:
 - (d) loss; or
 - (e) destruction; or
 - c. trailer used with a vehicle described in A.8.a. or A.8.b. above.

 Page 2
 Jeff Armstrong Sherry Armstrong August 7, 2014

The investigation we conducted found there is no coverage under this policy for this accident since Mr. Armstrong was driving his employer's vehicle in the course of business that was not listed on the policy Therefore, we are unable to pay for his damages.

If you believe there is additional information or circumstances we didn't include in our evaluation or have any questions about this decision, please contact me at the information below. I'd be more than happy to discuss this matter with you.

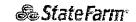
Sincerely,

Robert Miller Safeco Insurance

Safeco Insurance Company of Illinois (636) 326-8631 Fax: (888) 268-8840

Robert.Miller@Safeco.com

Providing Insurance and Financial Services Home Office, Bloomington, IL



April 29, 2016

Don Oswald PO Box 15

Bono AR 72416-0015

State Farm Claims PO Box 52250 Phoenix AZ 85072-2250

RE:

Claim Number:

04-419D-693

Date of Loss:

March 03, 2014

Our insured:

Don Oswald

Vehicle:

1994 Toyo STANDARD 4X2

VIN:

4TARN81A2RZ241304

Mileage:

251559 (observed at the time of inspection)

Dear Don Oswaid:

Your policy provides for payment of the actual cash value of your vehicle, less any applicable deductible. Actual cash value is determined by the market value, age, mileage and the condition of your vehicle at the time the loss occurred.

To assist us in determining actual cash value, we consider information obtained by our representatives, information provided by you, vehicle valuation services, and other sources. If you have additional information you wish us to consider, or if you believe we have not correctly determined the actual cash value of your vehicle, please contact us.

The amount payable to you was determined as follows:

Actual Cash Value
Plus: Taxes
Title Transfer:

\$3,075.00 \$0.00

\$10.00

Less: Deductible
Payment to Lienholder (if applicable)
Owner Retained Salvage

\$500.00 \$0.00 \$600.00

Total Net Payable to You:

\$1,985.00

As a State Farm® policyholder, you can enjoy the benefits of online registration. Benefits include checking the status of your claim online; managing your insurance information and accounts; and staying connected to State Farm. Just go to statefarm.com® to get registered. All you need to complete the process is your State Farm policy or account number, your email address, and about five minutes. If you are already registered, thank you!

04-419D-693 Page 2 April 29, 2016

Thank you for choosing State Farm for your insurance needs.

Sincerely,

Santini Sounthavanh Claim Representative (800) 869-4136 Ext. 6156923742 Fax: (855) 666-0964

State Farm Mutual Automobile Insurance Company

Providing Insurance and Financial Services Home Office, Bloomington, IL



April 11, 2014

Don Oswald PO Box 15 Bono AR 72416-0015 State Farm Claims P.O. Box 661001 Dallas TX 75266-1001

RE:

Claim Number:

04-419D-693

Date of Loss: Our Insured: March 03, 2014 Don Oswald

Injured Party:

Don Oswald

Dear Don Oswald:

We are writing to you to provide status on the handling of your Medical Payments Coverage claim.

The Medical Payments Coverage limits have been exhausted on behalf of Don Oswald. Maximum benefits payable per individuals are \$5,000.00, and final payment was made on April 11, 2014. Enclosed is a Payment Log which lists payment(s) made.

If there is other insurance coverage available, you may wish to consider submitting your future bills to that company.

If you have any questions, please contact us.

Sincerely,

Melody Suthers Claim Processor (866) 227-0010 Ext. 8162468056

Fax: (800) 726-4093

State Farm Mutual Automobile Insurance Company

Enclosure:

Payment Log

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Providing Insurance and Financial Services Home Office, Bloomington IL

ate Farm



August 29, 2014

Houston Law Firm PO Box 3076 Jonesboro AR 72403-3076

State Farm Claims P. O. Box 661001 Dallas TX 75266-1001

RE:

Claim Number:

04-419D-693

Date of Loss:

March 03, 2014

Our Insured:

Don Oswald

Your Client(s):

Don Oswald

Dear Mr. Houston:

We are extending an offer to Mr. Oswald for policy limits of \$25,000 for his Underinsured Motorist Claim. Our records reflect Mr. Oswald receives Medicaid benefits and St Bernard's file a medical lien.

Please contact me to discuss at your earliest convenience.

Sincerely,

Janice Shed Claim Representative (877) 494-2450 Fax: (888) 650-1919

State Farm Mutual Automobile Insurance Company

ರ್ಷಳ: DON OSWALD & HOUSTON LAW FIRM, HIS ATTORNEY VETEEN THOUSAND THREE HUNDRED FIFTY-EIGHT AND 22/100 DOLL to the 03-03-2014 3545514 40441154434 SECURED DOCUMENT WATERMARK APPEARS ON BACK, HOLD AT 45° ANGLE FOR VIEWING Wordor Table \$****19,358.22 VOID IF GREEN COLORED BACKGROUND IS MISSING

13-03-2014 INSURED OSWALD, DON & LINDA K

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Division of Medical Services Third Party Liability Unit

S TA TO SHE SHAPE

P.O. Box 1437, Slot S-296 Little Rock, AR 72203-1437 501-537-1070 · Fax: 501-682-1644

September 4, 2014

NOYL HOUSTON HOUSTON LAW FIRM, P.A. P O BOX 3076 JONESBORO, AR 72403

STATE FARM INSURANCE P O BOX 661001 DALLAS, TX 75266

RE:

Donald Oswald

CASE #:

155357

INSURED:

Unknown

CLAIM#:

04-419D-693

Dear Sir or Madam:

We have been notified that you represent the above recipient concerning an accident/incident on March 3, 2014. Donald Oswald is a Medicaid recipient and Medicaid has made payments in the amount of \$5,641.78 in connection with that accident/incident. For your convenience, an itemized listing of the payments is enclosed. This letter supersedes all previous correspondence from our office to date.

NOTE: Providers of service have one (1) year from the date of service to bill Medicaid for reimbursement. Please notify this office in advance of settlement to ensure the Medicaid amount is the correct updated amount. If you fail to notify us prior to settlement you may be responsible for additional payments made between the last letter received and the settlement date.

As a condition of Medicaid eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award, which may be obtained against any third party to the Arkansas Department of Human Services to the extent of any amount which may be paid by Medicaid for the benefit of the applicant.

When an action or claim is brought by a medical assistance recipient or his legal representative against a third party who may be liable for injury, disease, disability, or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the division's claims for reimbursement of the benefits provided to the recipient under the medical assistance program.

Letter to HOUSTON LAW FIRM / STATE FARM INSURANCE September 4, 2014 Page 2

No judgment, award, or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, or disability, in which the department has interest, shall be satisfied without first giving the department notice and a reasonable opportunity to establish its interest.

The Department of Human Services has an interest in this matter. Since we have a claim, please provide reasonable notice of all settlement negotiations and hearings so the department can take appropriate actions to protect the interest of the Medicaid Program. If you contend any of the payments listed are for services not attributable to your client's claim, please notify us immediately.

We appreciate your cooperation in this matter. Please do not hesitate to contact us at (501) 537-3424 should you have any questions.

Sincerely,

Kathryn Veasley

Kathryn Veasley, Quality Assurance Coordinator Division of Medical Services Administrative Services Section Third Party Liability Unit

KV:pc

Recipient Profile Request Arkansas Title XIX

From Date of Service:

3/3/2014 12:00:00 AM

To Date of Service:

9/4/2014 12:00:00 AM

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Provider Name and ID

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			\$850.00	\$0.00	\$0.00	\$850.00	\$24,932.33	Total:							0514164230929	
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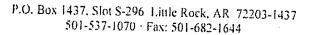
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Division of Medical Services Third Party Liability Unit





May 13, 2016

NOYL HOUSTON HOUSTON LAW FIRM PA 923 UNION PO BOX 3076 JONESBORO AR 72403

RE:

Donald Oswald

Case#:

155357

Insured:

Arkansas Highway and Transportation

DOL:

03/03/2014

Dear Sir/Madam:

In reference to our letter dated September 4, 2014, Medicaid has made <u>additional payments of</u> <u>\$3,390.59</u>. For your convenience, an itemized listing of the additional payments is attached.

This letter supersedes our previous correspondence dated May 11, 2016 relating to this incident.

NOTE: Providers of service have one (1) year from the date of service to bill Medicaid for reimbursement. Please notify this office in advance of settlement to ensure the Medicaid amount is the correct updated amount. If you fail to notify us prior to settlement you may be responsible for additional payments made between the last letter received and the settlement date.

As a condition of Medicaid eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Arkansas Department of Human Services to the extent of any amount which may be paid by Medicaid for the benefit of the applicant.

Please make the check payable to the Arkansas Medicaid and mail it to the following address:

Arkansas Department of Human Services Division of Medical Services ATTN: Third Party Liability Unit P. O. Box 1437, Slot S296 Little Rock, Arkansas 72203-1437

TAX ID#

LNM

Letter to HOUSTON LAW FIRM PA May 13, 2016 Page 2

When an action or claim is brought by a medical assistance recipient or his legal representative against a third party who may be liable for injury, disease, disability, or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the division's claims for reimbursement of the benefits provided to the recipient under the medical assistance program.

No judgment, award, or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease, or disability, in which the department as interest, shall be satisfied without first giving the department notice and a reasonable opportunity to establish its interest.

The payments attaches to past and future Medicaid payments. If additional payments are made by Medicaid, this unit will periodically update the amount of the payments.

The Department of Human Services has an interest in this matter. Since we have a claim, please provide reasonable notice of all settlement negotiations and hearings so the department can take appropriate action to protect the interest of the Medicaid Program.

We appreciate your cooperation in this matter. Please do not hesitate to contact us at (501) 537-3432 should you have any questions.

Sincerely,

LaDonna N. Mayo

LaDonna N. Mayo, Insurance/Healthcare Analyst II Division of Medical Services Administrative Services Section Third Party Liability Unit

Run Time: 5/13/16 9:16 AM

Confidential information of the Athansas Department of Human Services

Arkansas Title XIX

Recipient Profile Request

For Dates of Service Between Mar 3, 2014 and May 13, 2016

Date of Birth: 05/01/1952

		\$224.98	\$0.00	\$0.00	\$224,98	\$425.00							
ALLOWABLE	>											Total	0514363053864 - Total
365 - FEE ADJUSTED		\$224.98 01/08/2015	\$0.00	\$0.00	\$224.98	\$425.00	2/18/2014	12/18/2014 12/18/2014		DISPLACEMENT OF CERVICAL INTERVERTEBRAL	0514363053864 1 CONDUCTION STUDIES: A	0514363053864 1	PHY
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Recipient Profile Request

Date of Birth: 05/01/1952 Complete Recipient Name and ID: 8085042101 - OSWALD, DONALD For Dates of Service Between Mar 3, 2014 and May 13, 2016

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Ď		Total	0515009075693 1		iCX		7	· Total	0515008100716		Ē	2
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Diagnosis Code Desc			A TUNNEL SYNDROME		Desc Code				A ESSENTIAL HYPERTENSION	4019 -	Desc	
NDC First Du			Ę		Description				F		Description	
First Dta			01/06/2015 01/06/2015	,	First Dte of Svc				01/02/2015		of Svc	,
Last Ote			01/06/2015		Last Dte of Svc				01/02/2015 01/02/2015		of Svc	
Billed	00.0404	20.00	\$640,00		Billed Amount		00.12¢		\$21.00		Billed Amount	
Allwd	89.1614		\$191.68		Allwd Amt		\$18.00		\$18.00		Allwd	
Copay	\$0.00 \$0.00		\$0.00 \$0.00		Copay		\$0.00 \$0.00	7	\$0.00 \$0.00		Copay ins	
Ins	\$0.00		\$0.00		Ins Amt		\$0.00		\$0.00		Ant	
Paid	\$191.68		\$191.68		Paid Amount		\$18.00		\$18.00		Paid Amount	
			01/15/2015		Paid Date				01/15/2015		Paid Date	Ţ
Dti Major		ALLOWABLE,	365 - FEE ADJUSTED TO MAXIMUM	Description	Dti Major EOB			ALLOWABLE	365 - FEE S18.00 01/15/2015 ADJUSTED TO MAXIMUM	Description	Dtl Major EOB	Y'
Header				Description	Header EOB					Description	Header EOB	

E R D	1927	王重四	1927 NEA	₩ ₹ ₹ ₽	Z.	19	z		7	Ē	2 0	ш	z
MEMORIAL HOSPITAL	192756105 - NEA	MEMORIAL HOSPITAL	192756105 - NEA	MEMORIAL HOSPITAL	NEA	192756105 -	Name and ID	Provider		U5150096026 - Total	CLINIC	BAPTIST	NEA
3		M 0515009193497 2		8			Ç			3 - Total		J 0515009096026	******
3 COUNT HEMOGRAM AND PLATELET COUNT	85025 6 777 51 555	AUTO	81001 C 777		80048 G 777 Black tool		Procedure Code Desc				WRIST	0515009096026 1 MEDIAN NERVE AT	64721 2 ZZZ - REVISE
V7281 - PREOP A CARDIOVASC EXAM		A CARDIOVASC EXAM		A CARDIOVASC EXAM			Diagnosis Code Desc				SYNDROME	A TUNNEL	3540 CABBA
•		,		,		DAC In Tronditional	NDC					·	
01/02/2015 01/02/2015		01/02/2015 01/02/2015		01/02/2015 01/02/2015		240 10	First Dte			-		01/06/2016	
01/02/2015		01/02/2015		01/02/2015		of SVC	Last Dte				0100000	01/06/2015 01/06/2015	
\$134.00		\$121.00		\$308.00		Amount	Billed		\$1,085.00		\$1,085.00		
\$11.10		\$4.52		\$12.09		Amt Amount Amt	Allwd Copay		\$581.63		\$581.63		
\$0.00 \$0.00		\$0.00 \$0.00		\$0.00		Amount	Copay		\$0.00 \$0.00		\$0.00 80.00		
\$0.00		\$0.00	ļ	\$9.00		Amt	Ins		\$0.00		\$0.00		
\$11,10 0	ļ	\$4.52		\$12.09		≠_	Paid		\$581.63		\$581.63		
11/15/2015		01/15/2015		01/15/2015		Paid Date					01/15/2015		
365 - FEE ADJUSTED TO MAXIMUM	ALLOWABLE.	365 - FEE S4.52 01/15/2015 ADJUSTED TO MAXIMIIM	ALLOWABLE.	\$12.09 01/15/2015 ADJUSTED TO MAXIMUM	Description	E08	Drl Major			ALLOWABLE.	\$581.63 01/15/2015 ADJUSTED		Description
					Description	B03	Header						Description

184473002 -

Diagnosis Code Desc

NDC Description

First Dte

Last Dte of Syc

Billed

Allwd

Copay

lns Amt

Paid Amount

Paid Date

Dtl Major EOB Description

Header EOB Description

Run Trae: 5/13/16 9:16 AM

Confidential information of the Arkansas Department of Human Services

\$11.10 01/15/2015 ADJUSTED ALLOWABLE.

Version: 1.1

* Run Time: 3/13/16 5:18 AM

Confidential Information of the American Department of Human Services

Recipient Profile Request

For Dates of Service Between Mar 3, 2014 and May 13, 2016 Date of Birth: 05/01/1952

Provider					-									
Name and ID	ICN	Procedure Code Desc	Diagnosis Code Desc	NDC Description	First Dte	Last Die	Billed	Allwd	Сорау		Paid	Paid Date	Dtl Major	Header
192756105 - NEA						01.046	Amount	Amt	Amount	Amt	Amount	Paid Date	EOB Description	EOB Description
MEMORIAL HOSPITAL		4 EXAM OF CHEST	V7281 - PREOP A CARDIOVASC EXAM	•	01/02/2015	01/02/2015 01/02/2015	\$482.00	\$17.00	\$0.00	\$0.00	\$17.00	\$17.00 01/15/2015	4 ≽ ω	
192756105 - NEA BAPTIST MEMORIAL HOSPITAL		93005 G ZZZ - 5 ELECTROCARDIOGRAM, TRACING	V7281 - PREOP A CARDIOVASC EXAM	4	01/02/2015 01/02/2015	01/02/2015	\$213.00	\$17.00	\$0.00	\$0.00	\$17.00	\$17.00 01/15/2015	ALLOWABLE 365 - FEE ADJUSTED TO MAXIMUM	
0515009193497 - Total	- Total	**************************************											ALLOWABLE	
Provide							\$1,258.00	\$61.71	\$0.00	\$0.00	\$61.71			
Name and ID	iCN	Procedure Code Desc	Diagnosis Code Desc	NDC Description	First Dte	Last Dte	Billed . Amount	Allwd	Copay	Ans.	Paid	Paid Date	Dti Major	Header
NEA BAPTIST MEMORIAL MOSPITAL	0515013188655	M 0515013188655 1 MEDIAN NERVE AT WRIST	3540 - CARPAL A TUNNEL SYNDROME	,	01/06/2015 01/06/2015		\$2,952.00	ŏ .	\$0.00	\$0.00	\$320.00			Description
0515013188655 -	Total									······			ALLOWABLE.	
Provider							\$2,952.00	\$320.00	\$0.00	00.0\$	\$320,00			
Name and ID	iCN	Procedure Code Desc	Diagnosis Code Desc	NDC Description	First Dte	Last Dte	Billed	· .]		ins.	Paid		Dtl Major	Hoader
		99214 1 ZZZ - Established patient	3640 - CABBA			+	1000	Ame		A A	Amount	raid Date	Description [EOB Description
BAPTIST 3 CLINIC 3	0515154082519 1 office or other outpatient, vis 25 minutes	it typically	A TUNNEL SYNDROME		06/01/2015 06/01/2015	6/01/2015	\$131.00	\$70.05	\$0.00	\$0.00	\$70.05	\$70.05 06/11/2015		111111111111111111111111111111111111111
US10154082519 - Total	Total	***************************************										b	ALLOWABLE,	
Provider							\$131.00	\$70.05	\$0.00 \$	\$0.00	\$70.05			
Name and ID	Š	Procedure Code Desc	Diagnosis Code Desc		-	-	Billed	Ailwd	Copay	Ins	Paid		Dtl Major	Header
181611002 - NEA		01810 7 ZZZ -		ricaciipadii	01 046	of Syc	Amount			-	-	Paid Date		EOB Description
	0515162067865 1	1 PROCEDURES ON A NERVES, MUSCLES, TENDON, FA CIA, A	3540 - CARPAL TUNNEL SYNDROME	,	06/09/2015 06/09/2015	**************************************	\$560.00	\$167.72	\$0.00	00.00	\$167.72 06/18/2015			1000
0515162067865 - T	Total		7.141									> -	ALLOWABLE.	
							\$560.00	\$167.72	\$0.00 \$0.00	_	\$167,72		-	

Version: 1.1

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CANAL SALES SEE SALES SEE SALES

Recipient Profile Request

For Dates of Service Between Mar 3, 2014 and May 13, 2016 Date of Birth: 05/01/1952

				L L	!	1								
	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE		\$320.00 07/02/2015	\$0.00	\$0.00 \$	\$320,00	\$2,752.00		06/09/2015 06/09/2015	- 26	TUNNEL SYNDROME	MEDIAN NERVE AT A	Total 6	MEMORIAL HOSPITAL 0515174190083 - T.
	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	38.58 07/02/2015 AI	\$8.58 07	\$0.00	\$0.00 S	\$8.58	\$126.00	5/08/2015	06/08/2015 06/08/2015	- 0		THROMBOPLASTIN A TIME,PARTIAL(PTT) 64721 G 777 . BEVICE	, ch	MEMORIAL HOSPITAL 192756105 -
	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE	\$5.61 07/02/2015 A A	\$5.61 0	\$0.00	\$ 00.00	\$5.61	\$101.00	6/08/2015	06/08/2015 06/08/2015	- 0		PROTHROMBIN TIME A		MEMORIAL HOSPITAL 192756105- NEA
	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	\$11.10 07/02/2015 T	\$11.10 0	\$0.00	\$0.00	\$11.10	\$99.00)6/08/2015	06/08/2015 06/08/2015		A TUNNEL SYNDROME	DGRAM ET COUNT	0515174190083	
	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE.	\$4.52 07/02/2015	\$4.52	00.0\$	\$0.00	\$4.52	\$121.00	06/08/2015	06/08/2015 06/08/2015		A TUNNEL SYNDROME	URINALYSIS AUTO WISCOPE 85025 G 777 - BI OOD	2	MEMORIAL HOSPITAL 192756105 - NEA
	ADJUSTED TO MAXIMUM ALLOWABLE.	\$12.09 07/02/2015	\$12.09	\$0.00	\$0.00	\$12.09	\$308.00	06/08/2015	09/09/2015		SYNDROME			ر اب ر
Description	log i								ne no sour		3540 - CARPAL A TUNNEL	72 - Blood test, IP of blood		NEA BAPTIST M MEMORIAI
Header	Dti Major EOB	Paid Date	Paid	ins	Copay	Allwd Amt	Billed Amount	Last Dte	First Dte of Svc	NDC	Diagnosis Code Desc	Procedure Code Desc	Ğ	Name and ID 192756105 -
			\$581.63	\$0.00	\$0.00	\$581.63	\$1,085.00							Provider
	365 - FEE ADJUSTED TO MAXIMUM ALLOWABLE	\$581.63 06/18/2015	\$581.63	\$0.00	\$0.00	\$581.63	\$1,	06/09/201	06/09/2015 06/09/2015	4	A TUNNEL SYNDROME	WRIST WARNE AT	103096014	CLINIC CLINIC CT 1013
Header EOB Description	Dtl Major EOB Description	Paid Date	Paid Amount	t Amit	Copay Amount	Allwd	Amount	of Svc	af Svc	Description	Desc 3540 - CARPAL	64721 2 ZZZ - REVISE	7	184473002 - NEA

Part of the section o

Recipient Profile Request

Complete Recipient Name and ID: 8085042101 - OSWALD, DONALD Date of Birth: 05/01/1952 For Dates of Service Between Mar 3, 2014 and May 13, 2016

	5 - 5. .:	O YOLA	0	761,60	MEMORIAI HOSPITAL	NEA	1927	Nam	3	,		0515	CLINIC	NEA	1844		2 7
		Plot - HPISAC	11	U515216188668 - Total	MEMORIAL HOSPITAL		192756105 -	Name and ID	rovider			0515215070152 - Total			184473002 .	of Other	Frovider
				Total	0515216188668 1			Ç.	?			- Total	7610700176160	0645045040450			Č.
					ESONANCE	72141 G 777 .		Procedure Code Desc					IMAGNETIC RESONANCE A 1.231 -	72141 P ZZZ -		Code Desc	Dropped Today
•					A SPONDYLOSIS WITHOUT	7210 - CERVICAL		Diagnosis Code					CERVICALGIA	333		Desc	Diagnosis Code
					1			NDC Description					,			Description	NOC
					07/27/2015 07/27/2015			First Dte					07/27/2015 07/27/2015		1	of Svc	F
•					07/27/2015			Last Dre	-				07/27/2015		2,010	of Syc	
	\$15,769.00 \$3,390.59		\$3,423.00		\$3,423.00		אווסטות	Billed		4100.00	\$150.00		\$160.00		Hinosin	Billed	
\$	\$3,390.59		\$406,00		\$406.00		Ami	Allwd		00,00	6160 00		\$160.00		Am	Allwd	
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٠.	\$ 00.		8		0.00	\downarrow		îns		0.00			0.00	-	Amt	ins	
	3,390.59	4 10000	\$406.00		\$406.00		Amount	Paid		\$160.00		·	\$160.00		Amount	Paid	
					18/13/2015		raid Date	7					\$160.00 08/13/2015 FILL BY		Paid Date		
				ALLOWABLE.	365 - FEE S406.00 08/13/2015 ADJUSTED TO MAXIMUM	Description	EOH.	Dt Major				MEDICAID,	061 - PAID IN	Description	BOB	Dtl Major	
						Description	EOB	Header						Description	E08	Header	

Version: 1.1

RKANSAS STATE CLAIMS COMM. ION MOTOR VEHICLE ACCIDENT REPORT FORM

SECTION I	ld Ogranii and Karra		T FORIN	
	u Oswaid and Naren	1 Uswald	ADDRESS <u>205 E. (</u>)ak
	CITY & STATE	Rono AR	*****	
			TIME: 5:50 mm	
MOTOLL VEHICLE DAN	AGED TVoc small	ກຳຕະເນກ	Torroto	
		AI	DDRESS See above	_
of damage to car. An AHTD snow plant	on of accident, showir	ng how accident	happened, exact loss a	and extent
AR, at excessive speed left rear quarter panel c well as damage t	on ice, lost control and vee ausing it to spin violently, only pickup.	ound on U.S. Hight red into my (Southb injuring my neck, b	way 63 down "Bono Hill", pound) lane, hitting my truck pack, shoulder, arms and wr	Bono, in the ists., as
the following inform	en repaired? Yes (nation: Amount \$ 1) No () 1 ⁻ ,985.00*	but I retained the frepairs have been ment of \$1,985.00 (actual controlled and salvage) is attention and attach copies	ade, give
NAME		ADDRESS		
1. <u>N/A</u>	· · · · · · · · · · · · · · · · · · ·		<u>AMI</u>	OUNT
2.			<u> </u>	
3.	***			
Comprehensive: Ye	by Insurance? Yes (What is your o	deductible? \$ 100.00	,
oomsion. Yes (X)	No ()	What is your o	deductible? \$ 500.00	
NAME OF INSURANCE	E CARRIER A	DDRESS		
State Farm Insu	rance, PO Box 2371	, Bloomington	, IL 61702-2371	
	***		W	
Type of State Vehicle	involved snow pl	ow truck	License No.	
Driver <u>Jeffrey Arm</u>	stron@roperty of whice	ch State Agency	AR Hwy & Transport	ation Dep
If accident was	investigated by the	State Police	, give name of in	
officer: Cpl. Darr	en Crook	otate I office	, give name of in	vestigating
give name and title o	of officer making the in	if investigation vestigation:	was made by some other	er agency,
SECTION V		******		
set forth in the are true.	above statement,	nat he/she is fai and that he/	miliar with the matters she verily believes	and things that they
Donald Oswal	ed	-10	veressind.	
Donald Oswald, C	laimant	Kan	ren Oswald, Claiman	t
(Notary Seal)	Sworn to and subs	scribed before m	e at <u>Jonesboro</u> , AF	\
, , , , , , , , , , , , , , , , , , ,	on this day		2016. City,	
	OFFICIAL	. SEAL -#12692133	_ <u> </u>	- n A

My Commission Expires

PROPERTY DAMAGE/PERSONAL INJURY INCIDENT REPORT FORM

	nald Oswald and Karen OswaldADDRESS 205 E. Oak
_	(TV 0 CTATE
DATE OF INCID	ENT: March 3, 2014 ZIP CODE 72416
Give a brief desc	DENT: March 3, 2014 19 TIME 5:59 p.m. Cription of incident, showing how incident happened, exact loss and extent of damage or injury to person:
An Atten	or injury to person:
AR, at excepsion	speed on ice, lost control and veered into my (Southbound) lane, hitting my truck in the age to my pickup.
SECTION II *Ve	(If personal injury claim only, move on to Section IV) hicle was "totaled", but salvage was retained. See attached letter.
information: A	1 985 00 () If repairs have been made give the
NOTE: Attach a	Have you paid for the specific following
IT repairs have no NAME 1. N/A	of been made, list three estimates below and attach copies of each of them. ADDRESS AMOUNT
2	AMOUNT \$
3	\$\$\$\$\$\$\$
	\$
SECTION III	******
VAME OF INSUR	ered by insurance? Yes (X) No () deductible? \$ 500.00 ANCE CARRIER ADDRESS
VAME OF INSUR	ANCE CARRIER ADDRESS
<u>NAME OF INSUR</u> St. Farm Insu	ANOC 0
NAME OF INSUR St. Farm Insu SECTION IV	ANCE CARRIER ADDRESS rance PO Box 2371, Bloomington, IL 61702-2371
NAME OF INSUR St. Farm Insu SECTION IV s injured covered	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () If yes, is medical insurance?
NAME OF INSUR St. Farm Insu SECTION IV s injured covered	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () deductible? \$ N/A A Job-based Yes () No ()
NAME OF INSUR St. Farm Insu SECTION IV s injured covered yes, what is the	ANCE CARRIER ADDRESS PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () deductible? \$ N/A A Job-based Yes () No (X) B. Uninsured Motorist Yes (X) No () ANCE CARRIED
NAME OF INSUR St. Farm Insu SECTION IV s injured covered yes, what is the	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () deductible? \$ N/A A. Job-based Yes () No (X) B. Uninsured Motorist Yes (X) No () ANCE CARRIER ADDRESS Also \$5,000 in medical
SECTION IV St. Farm Insu SECTION IV s injured covered yes, what is the insurance of the	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes(X)No() If yes, is medical insurance: deductible? \$ N/A A. Job-based Yes()No(X) B. Uninsured Motorist Yes(X)No() ANCE CARRIER ADDRESS Also \$5,000 in medpay. PO Box 661001, Dallas, TX 75266-1001
SECTION IV St. Farm Insu SECTION IV s injured covered yes, what is the insurance of the	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes(X)No() If yes, is medical insurance: deductible? \$ N/A A. Job-based Yes()No(X) B. Uninsured Motorist Yes(X)No() ANCE CARRIER ADDRESS Also \$5,000 in medpay. PO Box 661001, Dallas, TX 75266-1001
SECTION IV St. Farm Insu SECTION IV s injured covered yes, what is the insurance of the	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes(X)No() If yes, is medical insurance: deductible? \$ N/A A. Job-based Yes()No(X) B. Uninsured Motorist Yes(X)No() ANCE CARRIER ADDRESS Also \$5,000 in medpay. PO Box 661001, Dallas, TX 75266-1001
NAME OF INSUR St. Farm Insu SECTION IV s injured covered f yes, what is the insured St. Farm Insu ECTION V incident was investig	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () If yes, is medical insurance: deductible? \$ N/A A. Job-based Yes () No (x) B. Uninsured Motorist Yes (X) No () C. Private Pay Yes (X) No () ANCE CARRIER ADDRESS Also \$5,000 in medpay. PO Box 661001, Dailas, TX 75266-1001 Arrance Co. PO Box 661001, Dailas, TX 75266-1001
NAME OF INSUR St. Farm Insu SECTION IV s injured covered f yes, what is the insured St. Farm Insu ECTION V incident was investig	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () If yes, is medical insurance: deductible? \$ N/A A. Job-based Yes () No (x) B. Uninsured Motorist Yes (X) No () C. Private Pay Yes (X) No () ANCE CARRIER ADDRESS Also \$5,000 in medpay. PO Box 661001, Dailas, TX 75266-1001 Arrance Co. PO Box 661001, Dailas, TX 75266-1001
NAME OF INSUR St. Farm Insu SECTION IV s injured covered f yes, what is the insured St. Farm Insu ECTION V incident was investig	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () If yes, is medical insurance: deductible? \$ N/A A. Job-based Yes () No (x) B. Uninsured Motorist Yes (X) No () C. Private Pay Yes (X) No () ANCE CARRIER ADDRESS Also \$5,000 in medpay. PO Box 661001, Dailas, TX 75266-1001 Arrance Co. PO Box 661001, Dailas, TX 75266-1001
SECTION IV s injured covered yes, what is the IAME OF INSURA St. Farm Insu ECTION V incident was invelaking the investig ECTION VI ne undersigned si atement, and that	ANCE CARRIER PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () If yes, is medical insurance: deductible? \$ N/A
NAME OF INSUR St. Farm Insu SECTION IV s injured covered f yes, what is the insurance of INSURA St. Farm Insu ECTION V incident was investig	ANCE CARRIER rance PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () If yes, is medical insurance: deductible? \$ N/A A. Job-based Yes () No (X) B. Uninsured Motorist Yes (X) No () C. Private Pay Yes (X) No () ANCE CARRIER ADDRESS Also \$5,000 in medpay. PO Box 661001, Dallas, TX 75266-1001 Action: Arkansas State Police, Cpl. Darren Crook. Jation: Arkansas State Police, Cpl. Darren Crook. Jates on oath that he/she is familiar with the matters and things set forth in the above the/she verily believes that they are true. Karen Osyanda
SECTION IV s injured covered yes, what is the SECTION V SECTION V incident was investig SECTION VI ne undersigned statement, and that Conald Oswald	ANCE CARRIER PO Box 2371, Bloomington, IL 61702-2371 by medical insurance? Yes (X) No () If yes, is medical insurance: deductible? \$ N/A

My Commission

| Difficial SEAL - #12892133 |
| Lisa M. Weatmoreland |
| CRAIGHEAD COUNTY |
| EXPIRES: 11-19-2025

Lisa m Westmoreland
Signature of Notary Public

BEFORE THE STATE CLAIMS COMMISSION OF THE STATE OF ARKANSAS

RECEIVED

DONALD OSWALD KAREN OSWALD

CLAIMANTS

V.

CLAIM NO. 16-0752-CC

ARKANSAS STATE HIGHWAY AND TRANSPORTATION DEPARTMENT

RESPONDENT

ANSWER

COMES THE RESPONDENT and for its Answer to the Complaint herein states:

- 1. The Respondent denies all allegations of the Complaint not admitted herein.
- 2. The Claimants' damages, if any, were not caused by the negligence of the Arkansas State Highway and Transportation Department or its employees.

WHEREFORE, the Respondent PRAYS for dismissal of the Complaint, for cost, and all proper relief.

ARKANSAS STATE HIGHWAY AND TRANSPORTATION DEPARTMENT

Bv

Steven W. Abed

Staff Attorney

AHTD, Legal Division

Arkansas Bar No. 96059

P. O. Box 2261

Little Rock, AR 72203-2261

(501) 569-2278

CERTIFICATE OF SERVICE

I, Steven W. Abed, certify that I have served the foregoing Answer upon the Claimant by mailing a true copy of same this 2nd of June, 2016, to:

Noyl Houston Houston Law Firm, P. A. 923 Union Jonesboro, AR 72403

Steven W Abed

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JUL 25 2016

BEFORE THE ARKANSAS STATE CLAIMS COMMISION

RECEIVED

KAREN OSWALD AND DONALD OSWALD

CLAIMANTS

V.

CLAIM NO. 16-0752-CC

ARKANSAS STATE HIGHWAY COMMISSION AND ARKANSAS STATE HIGHWAY AND TRANSPORTATION DEPARTMENT

RESPONDENTS

FULL AND COMPLETE SETTLEMENT AND RELEASE

For the sole consideration of Two Hundred Twenty Five Thousand Dollars and zero cents (\$225,000.00) that the undersigned, Karen Oswald and Donald Oswald, as husband and wife, do hereby release, discharge and forever acquit Jeffery Armstrong, Arkansas State Highway and Transportation Department, Arkansas State Highway Commission (collectively AHTD), their agents, employees, successors, and assigns liable or who might be liable in any way or in any manner as result of an accident which occurred on or about March 3, 2014, in Craighead County, Arkansas. This release shall operate as a full and final discharge of all causes of action in tort or in contract, or of any kind, of the undersigned, presently existing and which may arise in the future, of whatever kind and whatever nature against Jeffery Armstrong, Arkansas State Highway and Transportation Department, Arkansas State Highway Commission.

It is further expressly agreed by the undersigned that the amount to be paid herein is in full and final satisfaction of any and all claims including, but not limited to, any claim for bad faith, personal injury, wrongful death, damage to property, loss of consortium, and for any and all damages, known or unknown, or demands against Jeffery Armstrong, Arkansas State Highway and Transportation Department, Arkansas State Highway Commission which may arise out of said accident.

The undersigned hereby accepts AHTD's unconditional promise not to dispute liability for said claim filed by the undersigned before the Arkansas State Claims Commission as full and complete consideration as described above. It is understood that tender of payment by warrant will be made payable to: the undersigned, Karen Oswald and Donald Oswald, as husband and wife and their attorney, Noyl Houston in the amount of Two Hundred Twenty Five Thousand Dollars and zero cents (\$225,000.00), which has been agreed to by the undersigned. This settlement, in accordance with Arkansas State Law, is contingent upon approval from the Arkansas State Claims Commission, Joint Budget Committee or Legislative Council and the Arkansas General Assembly. The undersigned hereby accepts the aforementioned sum as full, sufficient, final consideration, and final payment with respect to the above-mentioned claim before the Arkansas State Claims Commission for all claims past, present, and future that are a result of the accident of March 3, 2014.

The undersigned, hereby declares the terms of this settlement have been completely read, are fully understood, and are voluntarily accepted for the purpose of making a full and final compromise, adjustment, and settlement of any and all claims, disputed or otherwise, for the express purpose of dismissing and precluding forever any and all claims, including further or additional claims arising out of the aforesaid matter.

EXECUTED THIS	SA DAY OF	July	, 2016.
Karen Oswald, Claimant		mald Osur	
Social Security Number	energy control of the	cial Security Number	-

SUBSCRIBED AND SWORN to before me this 15 day of July, 2016.

NOTARY PUBLIC

My Commission Expires:



Witnessed and approved by:

Noyl Houston

Attorney for Claimants

Prepared by:

Steven W. Abed Staff Attorney

Arkansas State Highway

And Transportation Department

STATE CLAIMS COMMISSION DOCKET OPINION

Amount of Claim \$ 375,500.00	Claim No16-0752-CC
	· · · · · · · · · · · · · · · · · · ·
Donald & Karen Oswald Claimant	Noyl Houston, Attorney Claimant
vs. AR Highway & Transportation Dept. Respondent	David Dawson, Attorney
State of Arkansas	Respondent
May 17, 2016 Date Filed	Property Damage, Personal Injury, Pain & Suffering
FINDING OF	FACTS
This claim was filed for property damage, po \$375,500.00 against Arkansas Highway & T	ersonal injury and pain & suffering in the amount of ransportation Department.
Present at the hearing on August 11, 2016 w the Respondent, represented by David Daws	as the Claimant, represented by Noyl Houston and son, Staff Attorney.
Commission by the Respondent, along with	ed by the claim parties were submitted to the Claims the Respondent's recommendation of payment at of this claim, in a letter or Answer received on
by the parties in the amount of \$225,000.0	ly allows this "Negotiated Settlement Agreement" 00 and will include the claim in a claims bill to the Session 2016, for subsequent approval and
IT IS SO ORDERED.	
•	
(See Back of Op.	inion Form)
CONCLU	
Upon consideration of all the facts, as stated unanimously allows this claim in the amoun in a claims bill to be submitted to the 91st for subsequent approval and payment.	d above, the Claims Commission hereby at of \$225,000.00 and will include the claim General Assembly, Fiscal Session 2016,
Date of HearingAugust 11, 2016	0.000
Date of Disposition August 11, 2016	Chairman
	Myas 110ther