



**CITY OF RIALTO
LIABILITY
CLAIM FOR DAMAGES
TO PERSON OR PROPERTY**

CITY CLERK'S DATE STAMP
CITY OF RIALTO
2025 JAN -6 PM 4: 14
**RECEIVED
CITY CLERK**

1. Claims for death, injury to person, or to personal property must be filed not later than six (6) months after the occurrence (Gov. Code §911.2).
2. Claims for damages to real property must be filed not later than one (1) year after the occurrence (Gov. Code §911.2).
3. READ ENTIRE CLAIM FOR BEFORE FILING
4. ATTACH SEPARATE SHEETS, IF NECESSARY, TO GIVE FULL DETAILS

RETURN TO:
Rialto City Clerk's Office
Mail: 150 S. Palm Ave., Rialto, CA 92376
Address: 290 W. Rialto Ave., Rialto, CA 92376

CLAIMANT INFORMATION:

_____ Maida Barrios _____
FULL NAME

_____ _____ _____
HOME ADDRESS INCLUDING CITY, STATE & ZIP

_____ _____ _____
BUSINESS ADDRESS INCLUDING CITY, STATE & ZIP

_____ _____ _____
ADDRESS AT WHICH CLAIMANT DESIRES TO RECEIVE
NOTICES OR COMMUNICATIONS REGARDING THIS CLAIM
(if different from home address provided above): SAME

_____ _____ _____
DATE OF BIRTH Hard of hearing

_____ _____ _____
HOME TELEPHONE NO. Husband (only text)

_____ _____ _____
BUSINESS TELEPHONE NO.

1. WHEN DID DAMAGE OR INJURY OCCUR? DATE: Aug 22, 2024 TIME: 7:20 AM PM

2. PLACE OF ACCIDENT (OCCURRENCE) BE SPECIFIC – Describe fully and (if applicable) locate on diagram on reverse side of this sheet. Where appropriate, give street names and addresses, measurements and landmarks.

Foothill Blvd.

3. HOW DID DAMAGE OR INJURY OCCUR? Hit
Police ~~hit~~ my car

4. WERE POLICE AT THE SCENE? YES NO WERE PARAMEDICS AT THE SCENE? YES NO

5. WHAT PARTICULAR ACT OR OMISSION DO YOU CLAIM CAUSED THE INJURY OR DAMAGES? Give the name of the city/town employee causing the injury or damage, if known.

Rialto Police

6. GIVE TOTAL AMOUNT OF CLAIM Include estimate of amount of any prospective injury or damage \$ _____

HOW WAS THE ABOVE AMOUNT COMPUTED? Be specific, list doctor bills, repair estimates, etc. Please attach 2 estimates.

DAMAGES INCURRED TO DATE:

Item/Date: <u>see attach</u>	Amount: \$ <u>18,084.96</u>
Item/Date: <u>pages</u>	Amount: \$ _____
<u>2 Hospital Bills</u>	<u>miss work 2 jobs</u>
<u>1 Ambulance</u>	<u>Little pain & suffering</u>

TOTAL AMOUNT CLAIMED AS OF PRESENTATION OF THIS CLAIM:

\$ _____

ESTIMATED PROSPECTIVE DAMAGES, AS FAR AS KNOWN:

Item/Date: See attach sheets

Amount: \$ _____

Item/Date: _____

Amount: \$ _____

TOTAL ESTIMATED AMOUNT PROSPECTIVE DAMAGES:

\$ _____

7. WITNESSES TO DAMAGE OR INJURY List all persons known to have information (attach additional pages, if necessary)

NAME: Video from Bank America

NAME: _____

ADDRESS: Foothill in Rialto

ADDRESS: _____

TELEPHONE: () _____

TELEPHONE: () _____

8. IF INJURED, PROVIDE NAME, CONTACT INFORMATION AND DATE/TIME DOCTOR(S) OR HOSPITAL(S) VISITED:

NAME: Arrowhead Regional Medical Center

NAME: Arrowhead Regional Medical Center

ADDRESS: 400 N. Pepper Ave

ADDRESS: 400 N. Pepper Ave

Colton, CA 92324

Colton, CA 92324

TELEPHONE: (909) 580-1000

TELEPHONE: (909) 580-1000

DATE: Aug 22, 2024 TIME: 7:45 AM PM

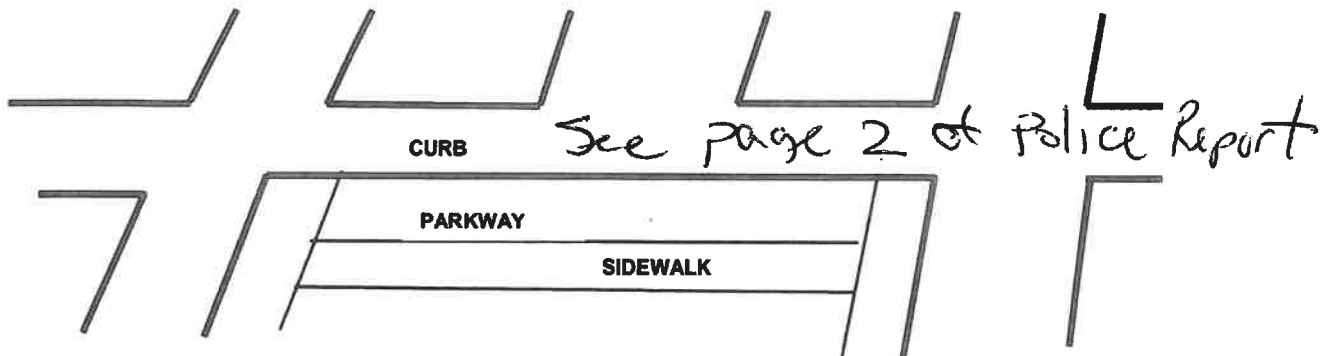
DATE: Aug 27, 2024 TIME: 12:00 AM PM

9. PLEASE READ THE FOLLOWING CAREFULLY:

For all vehicle accident claims, place on the following diagram, the names of streets, including NORTH, EAST, SOUTH AND WEST directions. Indicate place of accident by "X" and by showing house numbers or distances to street corners.

If a city/town vehicle was involved, designate by letter "A" location of the City/Town vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City/Town vehicle; location of City/Town vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

⇒ NOTE: IF THE DIAGRAM BELOW DOES NOT FIT THE SITUATION, PLEASE ATTACH A PROPER DIAGRAM SIGNED BY THE CLAIMANT.



I HAVE READ THE FOREGOING CLAIM AND KNOW THE CONTENTS THEREOF; AND CERTIFY THAT THE SAME IS TRUE OF MY OWN KNOWLEDGE EXCEPT AS TO THOSE MATTERS WHICH ARE HEREIN STATED UPON MY INFORMATION AND BELIEF; AND AS TO THOSE MATTERS I BELIEVE THEM TO BE TRUE.

I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

SIGNATURE OF CLAIMANT OR AGENT

Maida Barrios

TYPE OR PRINT NAME

11-12-2024

DATE

RELATIONSHIP TO CLAIMANT

NOTE: PRESENTATION OF A FALSE CLAIM IS A FELONY (CA PENAL CODE 72)
RETURN CLAIM TO: RIALTO CITY CLERK'S OFFICE - 150 S. PALM AVE., RIALTO, CA 92376


Doctor bill \$ 103.85 see ①
Doctor bill \$ 204.61 see ②
Ambulance bill \$1,655.45 see ③
Doctor bill \$ 6,321.83 see ④
Doctor bill \$ 340.17 see ⑤
Arrowhead Hospital bill \$ 1,470.97 see ⑥
Arrowhead Hospital bill \$ 3,943.58 see ⑦
Missed Work Rainbow Store PTO \$ 208.00 see ⑧
Missed Work Rainbow Store PTO \$ 224.00 see ⑨
Duarte High School Work Missed 4 days \$ 612.50 see ⑩
Pain and Suffering \$ 3,000 couldn't stand pain
for 2 weeks.

SPECIAL CONDITIONS		NUMBER INJURED 1	HIT & RUN FELONY <input type="checkbox"/>	CITY SAN BERNARDINO	JUDICIAL DISTRICT	LOCAL REPORT NUMBER 2024-00099849	
On-Duty Emergency Vehicle		NUMBER KILLED 0	HIT & RUN MISDEMEANOR <input type="checkbox"/>	COUNTY SAN BERNARDINO	REPORTING DISTRICT	BEAT	DAY OF WEEK S M T W T F S
LOCATION	COLLISION OCCURRED ON E FOOTHILL BLVD				MO. DAY YEAR 08/22/2024	TIME (2400) 0739	NCIC # 3610
	MILEPOST INFORMATION				GPS COORDINATES		OFFICER I.D. 50772
	FEET/MILES OF				LATITUDE 34.1067587958568 LONGITUDE -- -117.361628079017		PHOTOGRAPHS BY: <input type="checkbox"/> NONE
	<input type="checkbox"/> AT INTERSECTION WITH				STATE HWY REL		RIALTO PD
<input checked="" type="checkbox"/> OR: 520 FEET/MILES-- W OF NORTH ACACIA AVENUE				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
PARTY 01	DRIVER'S LICENSE NUMBER B6514149	STATE CA	CLASS C	AIR BAG M	SAFETY EQUIP. H	VEH. YEAR 2020	MAKE/MODEL/COLOR FORD BLACK
DRIVER	NAME (FIRST, MIDDLE, LAST) ERICA JEAN DUQUE				OWNER'S NAME <input type="checkbox"/> SAME AS DRIVER		
PEDESTRIAN	STREET ADDRESS 128 N WILLOW AVE				OWNER'S ADDRESS <input checked="" type="checkbox"/> SAME AS DRIVER		
PARKED VEHICLE	CITY/STATE/ZIP RIALTO CA 92376				DISPOSITION OF VEHICLE ON ORDERS OF: <input checked="" type="checkbox"/> OFFICER <input type="checkbox"/> DRIVER <input type="checkbox"/> OTHER		
BICYCLIST	SEX F	HAIR BRO	EYES BRO	HEIGHT 5 1	WEIGHT 145	Mo. BIRTHDATE Day Year 07/20/1979	RACE W
OTHER	HOME PHONE (909)820-2550		BUSINESS PHONE		VEHICLE IDENTIFICATION NUMBER: 1FM5K8AB5LGC99765		
INSURANCE CARRIER SELF INSURED		POLICY NUMBER		VEHICLE TYPE 48		DESCRIBE VEHICLE DAMAGE <input type="checkbox"/> UNK. <input type="checkbox"/> NONE <input checked="" type="checkbox"/> MINOR	
DIR OF TRAVEL E		ON STREET OR HIGHWAY E FOOTHILL BLVD		SPEED LIMIT 25		SHADE IN DAMAGED AREA 	
PARTY 02	DRIVER'S LICENSE NUMBER B7535800	STATE CA	CLASS C	AIR BAG M	SAFETY EQUIP. G	VEH. YEAR 2022	MAKE/MODEL/COLOR TOYOTA WHITE
DRIVER	NAME (FIRST, MIDDLE, LAST) MAIDA BARRIOS				OWNER'S NAME <input checked="" type="checkbox"/> SAME AS DRIVER		
PEDESTRIAN	STREET ADDRESS				OWNER'S ADDRESS <input checked="" type="checkbox"/> SAME AS DRIVER		
PARKED VEHICLE	CITY/STATE/ZIP RIALTO CA 92376				DISPOSITION OF VEHICLE ON ORDERS OF: <input checked="" type="checkbox"/> OFFICER <input type="checkbox"/> DRIVER <input type="checkbox"/> OTHER		
BICYCLIST	SEX F	HAIR BLK	EYES BRO	HEIGHT 5-1	WEIGHT 135	Mo. BIRTHDATE Day Year	RACE H
OTHER	HOME PHONE		BUSINESS PHONE		VEHICLE IDENTIFICATION NUMBER:		
INSURANCE CARRIER MERCURY INSURANCE GROUP		POLICY NUMBER		VEHICLE TYPE 01		DESCRIBE VEHICLE DAMAGE <input type="checkbox"/> UNK. <input type="checkbox"/> NONE <input checked="" type="checkbox"/> MINOR	
DIR OF TRAVEL W		ON STREET OR HIGHWAY EAST FOOTHILL BLVD		SPEED LIMIT 25		SHADE IN DAMAGED AREA 	
PARTY	DRIVER'S LICENSE NUMBER	STATE	CLASS	AIR BAG	SAFETY EQUIP.	VEH. YEAR	MAKE/MODEL/COLOR
DRIVER	NAME (FIRST, MIDDLE, LAST)				OWNER'S NAME <input type="checkbox"/> SAME AS DRIVER		
PEDESTRIAN	STREET ADDRESS				OWNER'S ADDRESS <input type="checkbox"/> SAME AS DRIVER		
PARKED VEHICLE	CITY/STATE/ZIP				DISPOSITION OF VEHICLE ON ORDERS OF: <input type="checkbox"/> OFFICER <input type="checkbox"/> DRIVER <input type="checkbox"/> OTHER		
BICYCLIST	SEX	HAIR	EYES	HEIGHT	WEIGHT	Mo. BIRTHDATE Day Year	RACE
OTHER	HOME PHONE		BUSINESS PHONE		VEHICLE IDENTIFICATION NUMBER:		
INSURANCE CARRIER		POLICY NUMBER		VEHICLE TYPE		DESCRIBE VEHICLE DAMAGE <input type="checkbox"/> UNK. <input type="checkbox"/> NONE <input type="checkbox"/> MINOR	
DIR OF TRAVEL		ON STREET OR HIGHWAY		SPEED LIMIT		SHADE IN DAMAGED AREA 	
PREPARER'S NAME Mata 50772		DISPATCH NOTIFIED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		REVIEWER'S NAME Siems, Michael		DATE REVIEWED 09/26/2024	

DATE OF COLLISION (MO. DAY YEAR) 08/22/2024	TIME (2400) 0739	NCIC # 3610	OFFICER I.D. 50772	NUMBER 2024-00099849
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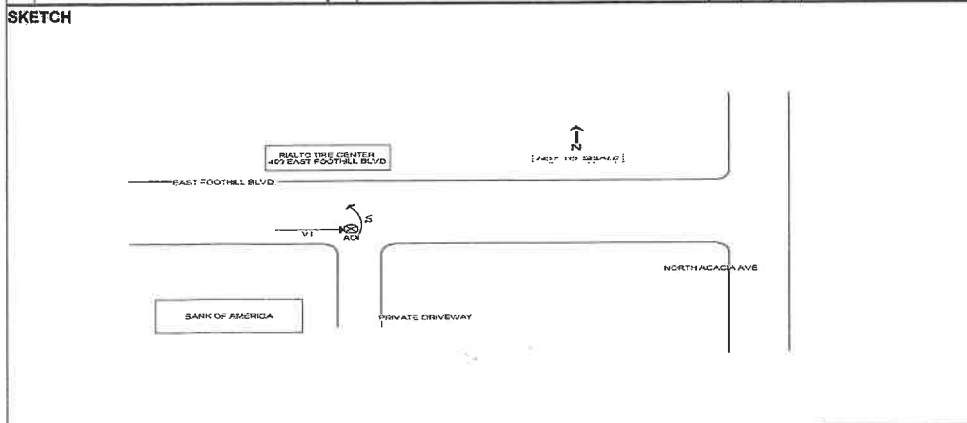
PROPERTY DAMAGE	OWNER'S NAME CITY OF RIALTO	OWNER'S ADDRESS 128 N WILLOW AVE RIALTO CA 92376	NOTIFIED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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DESCRIPTION OF DAMAGE
SCRATCHES TO PUSH BAR

<p>SEATING POSITION</p>  <p>1 - DRIVER 2 TO 6 - PASSENGERS 7 - STATION WAGON REAR 8 - REAR OCC. TRK. OR VAN 9 - POSITION UNKNOWN 0 - OTHER</p>	<p>SAFETY EQUIPMENT</p> <p>OCCUPANTS A - NONE IN VEHICLE B - UNKNOWN C - LAP BELT USED D - LAP BELT NOT USED E - SHOULDER HARNESS USED F - SHOULDER HARNESS NOT USED G - LAP/SHOULDER HARNESS USED H - LAP/SHOULDER HARNESS NOT USED J - PASSIVE RESTRAINT USED K - PASSIVE RESTRAINT NOT USED P - NOT REQUIRED</p> <p>CHILD RESTRAINT Q - IN VEHICLE USED R - IN VEHICLE NOT USED S - IN VEHICLE USE UNKNOWN T - IN VEHICLE IMPROPER USE U - NONE IN VEHICLE</p> <p>M / C BICYCLE HELMET DRIVER PASSENGER V - NO X - NO W - YES Y - YES</p>	<p>AIR BAG B - UNKNOWN L - AIR BAG DEPLOYED M - AIR BAG NOT DEPLOYED N - OTHER P - NOT REQUIRED</p> <p>EJECTED FROM VEHICLE 0 - NOT EJECTED 1 - FULLY EJECTED 2 - PARTIALLY EJECTED 3 - UNKNOWN</p>	<p>INATTENTION CODES A - CELLPHONE HANDHELD B - CELLPHONE HANDSFREE C - ELECTRONIC EQUIPMENT D - RADIO / CD E - SMOKING F - EATING G - CHILDREN H - ANIMALS I - PERSONAL HYGIENE J - READING K - OTHER</p>
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ITEMS MARKED BELOW FOLLOWED BY AN ASTERISK (*) SHOULD BE EXPLAINED IN THE NARRATIVE.

PRIMARY COLLISION FACTOR LIST NUMBER (#) OF PARTY AT FAULT	TRAFFIC CONTROL DEVICES	01	02	SPECIAL INFORMATION	01	02	MOVEMENT PRECEDING COLLISION
02 A VC SECTION VIOLATED: 22107 VC-I <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	A CONTROLS FUNCTIONING			A HAZARDOUS MATERIAL			A STOPPED
B OTHER IMPROPER DRIVING*	B CONTROLS NOT FUNCTIONING*			B CELL PHONE HANDHELD IN USE	X		B PROCEEDING STRAIGHT
C OTHER THAN DRIVER*	C CONTROLS OBSCURED			C CELL PHONE HANDSFREE IN USE			C RAN OFF ROAD
D UNKNOWN*	D NO CONTROLS PRESENT / FACTOR*	X	X	D CELL PHONE NOT IN USE			D MAKING RIGHT TURN
	TYPE OF COLLISION			E SCHOOL BUS RELATED		X	E MAKING LEFT TURN
	A HEAD - ON			F 75 FT MOTORTRUCK COMBO			F MAKING U TURN
	B SIDE SWIPE			G 32 FT TRAILER COMBO			G BACKING
	C REAR END			H			H SLOWING / STOPPING
WEATHER (MARK 1 TO 2 ITEMS)	D BROADSIDE			I			I PASSING OTHER VEHICLE
X A CLEAR	E HIT OBJECT			J			J CHANGING LANES
B CLOUDY	F OVERTURNED			K			K PARKING MANEUVER
C RAINING	G VEHICLE / PEDESTRIAN			L			L ENTERING TRAFFIC
D SNOWING	H OTHER*			M			M OTHER UNSAFE TURNING
E FOG / VISIBILITY FT.				N			N XING INTO OPPOSING LANE
F OTHER:	MOTOR VEHICLE INVOLVED WITH			O			O PARKED
G WIND	A NON - COLLISION						P MERGING
	B PEDESTRIAN						Q TRAVELING WRONG WAY
LIGHTING	C OTHER MOTOR VEHICLE		01 02	OTHER ASSOCIATED FACTOR(S) (MARK 1 TO 2 ITEMS)			R OTHER*
X A DAYLIGHT	D MOTOR VEHICLE ON OTHER ROADWAY			A VC SECTION VIOLATION: <input type="checkbox"/> YES <input type="checkbox"/> NO			
B DUSK - DAWN	E PARKED MOTOR VEHICLE			B VC SECTION VIOLATION: <input type="checkbox"/> YES <input type="checkbox"/> NO			
C DARK - STREET LIGHTS	F TRAIN			C VC SECTION VIOLATION: <input type="checkbox"/> YES <input type="checkbox"/> NO			
D DARK - NO STREET LIGHTS	G BICYCLE			D	X	X	SOBRIETY - DRUG PHYSICAL (MARK 1 TO 2 ITEMS)
E DARK - STREET LIGHTS NOT FUNCTIONING*	H ANIMAL:			E VISION OBSCUREMENT:			A HAD NOT BEEN DRINKING
ROADWAY SURFACE	I FIXED OBJECT:			F INATTENTION*:			B HBD - UNDER THE INFLUENCE
X A DRY	J OTHER OBJECT:			G STOP & GO TRAFFIC			C HBD - NOT UNDER INFLUENCE*
B WET				H ENTERING / LEAVING RAMP			D HBD - IMPAIRMENT UNKNOWN*
C SNOWY - ICY	PEDESTRIAN'S ACTIONS			I PREVIOUS COLLISION			E UNDER DRUG INFLUENCE*
D SLIPPERY (MUDDY, OILY, ETC.)	X A NO PEDESTRIANS INVOLVED.			J UNFAMILIAR WITH ROAD			F IMPAIRMENT - PHYSICAL*
ROADWAY CONDITIONS (MARK 1 TO 2 ITEMS)	B CROSSING IN CROSSWALK - AT INTERSECTION			K DEFECTIVE VEH. EQUIP.: <input type="checkbox"/> YES <input type="checkbox"/> NO			G IMPAIRMENT NOT KNOWN
A HOLES, DEEP RUT*	C CROSSING IN CROSSWALK - NOT AT INTERSECTION			L UNINVOLVED VEHICLE			H NOT APPLICABLE
B LOOSE MATERIAL ON ROADWAY*	D CROSSING - NOT IN CROSSWALK			M OTHER*:			I SLEEPY / FATIGUED*
C OBSTRUCTION ON ROADWAY*	E IN ROAD - INCLUDES SHOULDER			N NONE APPARENT			
D CONSTRUCTION - REPAIR ZONE	F NOT IN ROAD		X	O RUNAWAY VEHICLE			
E REDUCED ROADWAY WIDTH	G APPROACHING / LEAVING SCHOOL BUS						
F FLOODED*							
G OTHER*:							
H NO UNUSUAL CONDITIONS							



MISCELLANEOUS

The area of impact is approximately 520 feet west of the west curb line prolongation of North Acacia Avenue and 21 feet north of the south curb line of East Foothill Blvd.

DATE OF COLLISION (MO. DAY YEAR) 08/22/2024				TIME (2400) 0739	NCIC # 3610	OFFICER I.D. 50772					NUMBER 2024-00099849								
WITNESS ONLY	PASSENGER ONLY	AGE	SEX	EXTENT OF INJURY ("X" ONE)				INJURED WAS ("X" ONE)					PARTY NUMBER	SEAT POS.	AIR BAG	SAFETY EQUIP.	EJECTED		
				FATAL INJURY	SEVERE INJURY	OTHER VISIBLE INJURY	COMPLAINT OF PAIN	DRIVER	PASS.	PED.	BICYCLIST	OTHER							
<input type="checkbox"/> #	<input type="checkbox"/>	47	F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	02	1	M	G	0	
NAME / D. O. B. / ADDRESS MAIDA BARRIOS												07/17/1977			TELEPHONE (562)417-3159				
(INJURED ONLY) TRANSPORTED BY: AMR												TAKEN TO: ARMC							
DESCRIBE INJURIES COMPLAIN OF PAIN TO NECK AND BACK																			
																<input type="checkbox"/>		VICTIM OF VIOLENT CRIME NOTIFIED	
<input type="checkbox"/> #	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAME / D. O. B. / ADDRESS												TELEPHONE							
(INJURED ONLY) TRANSPORTED BY:												TAKEN TO:							
DESCRIBE INJURIES																			
																<input type="checkbox"/>		VICTIM OF VIOLENT CRIME NOTIFIED	
<input type="checkbox"/> #	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAME / D. O. B. / ADDRESS												TELEPHONE							
(INJURED ONLY) TRANSPORTED BY:												TAKEN TO:							
DESCRIBE INJURIES																			
																<input type="checkbox"/>		VICTIM OF VIOLENT CRIME NOTIFIED	
<input type="checkbox"/> #	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAME / D. O. B. / ADDRESS												TELEPHONE							
(INJURED ONLY) TRANSPORTED BY:												TAKEN TO:							
DESCRIBE INJURIES																			
																<input type="checkbox"/>		VICTIM OF VIOLENT CRIME NOTIFIED	
<input type="checkbox"/> #	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAME / D. O. B. / ADDRESS												TELEPHONE							
(INJURED ONLY) TRANSPORTED BY:												TAKEN TO:							
DESCRIBE INJURIES																			
																<input type="checkbox"/>		VICTIM OF VIOLENT CRIME NOTIFIED	
PREPARER'S NAME Mata				I.D. NUMBER 50772				MO. DAY YEAR 08/22/2024				REVIEWER'S NAME Siems, Michael				MO. DAY YEAR 09/26/2024			

NARRATIVE/SUPPLEMENTAL

CHP 556 (Rev 7-90) OPI 042

DATE OF INCIDENT/OCCURRENCE 08/22/2024		TIME (2400) 0739	NCIC NUMBER 3610	OFFICER I.D. NUMBER 50772	NUMBER 2024-00099849
X ONE <input checked="" type="checkbox"/> Narrative <input type="checkbox"/> Supplemental	*X* ONE <input checked="" type="checkbox"/> Collision report <input type="checkbox"/> Other:	TYPE SUPPLEMENTAL (*X* APPLICABLE) <input type="checkbox"/> BA update <input type="checkbox"/> Fatal <input type="checkbox"/> Hit and run update <input type="checkbox"/> Hazardous materials <input type="checkbox"/> School bus <input type="checkbox"/> Other:			
CITY/COUNTY/JUDICIAL DISTRICT SAN BERNARDINO			CITY/COUNTY/JUDICIAL DISTRICT SAN BERNARDINO		REPORTING DISTRICT/BEAT CITATION NUMBER
LOCATION/SUBJECT E FOOTHILL BLVD / NORTH ACACIA AVENUE				STATE HIGHWAY RELATED <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
See attached document.					
PREPARER'S NAME AND I.D. NUMBER Mata 50772		DATE 08/22/2024	REVIEWER'S NAME Siems, Michael		DATE 09/26/2024

Use previous editions until depleted.

DATE OF INCIDENT	TIME	NCIC NUMBER	OFFICER I.D.	REPORT NUMBER
08/22/2024	0739	3610	50772	2024-99849

NOTIFICATION:

On 8/22/2024 at about 0752 hours, I was notified of a traffic collision involving a Rialto Police Department on-duty police officer. Rialto PD requested assistance with the collision investigation. The collision occurred at about 0739 hours, west of the intersection of East Foothill Blvd. and North Acacia Avenue, in the City of Rialto.

All speeds, times and measurements are approximate. All measurements were obtained by satellite mapping.

PARTIES:

Driver #1 (Duque, Erica) is an active on-duty police officer for the City of Rialto. I spoke to Duque, while at the collision scene. She was uninjured during the collision and did not complain of any pain. She provided a statement reference the collision.

Driver #2 (Barrios, Maida) was identified by her valid, California Driver's License. I spoke to Barrios at Arrowhead Regional Medical Center Emergency Waiting Room, located at 400 North Pepper Avenue, Rialto, CA. At the time of my contact, Barrio's complained of pain to her back and neck. She initially denied medical aid, when offered immediately after the collision. She later requested an ambulance for a transport to the hospital.

VEHICLES:

Vehicle #1 – 2020 Ford Explorer. Black/White. CA-1600717 (Exempt)
City of Rialto, On-Duty Police Vehicle Unit, Unit #1613

Vehicle #1 was moved out of the roadway, prior to my arrival. I located the vehicle in a nearby parking lot. There was a minor scratch on the vehicle's push bar as a result of the collision.

Vehicle #2 – 2022 Toyota. Camry. CA –

Vehicle #1 was moved out of the roadway, prior to my arrival. I located the vehicle in a nearby parking lot, parked within a parking stall. There was collision damage to the driver side rear fender and rear bumper as a result of the collision.

STATEMENTS:

Driver #1 was on-duty at the time of the collision. Duque stated she was driving eastbound in the #2 lane of East Foothill Blvd, west of the intersection of North Acacia Avenue. She came to a stop because several vehicles were backed up, due to the ongoing roadway construction. She looked away from the roadway to check her air conditioning settings then slowly proceeded straight. Duque recalled a large glare from the sunlight facing her as she proceeded to go east. As she proceeded straight, a white vehicle came into view and Duque immediately pressed on the brakes to come to a stop. Duque felt an impact to the front of her vehicle, where the front of V1 collided with the rear driver side of V2. Duque contacted

PREPARER'S NAME	I.D. NUMBER	DATE	REVIEWER'S NAME	DATE
A. Mata	50772	09/04/2024		

DATE OF INCIDENT	TIME	NCIC NUMBER	OFFICER I.D.	REPORT NUMBER
08/22/2024	0739	3610	50772	2024-99849

1 Driver #2 and asked if she needed medical aid. Driver #2 denied medical aid and both vehicles were later moved to a
 2 nearby parking lot.

3
 4 Driver #2 was facing northbound and stopped to enter the roadway from a private business parking lot. She waited for
 5 several vehicle to pass, due to ongoing construction. Barrios stated she observed the police vehicle stopped (after vehicle
 6 proceeded straight). Barrios believed Vehicle #1 gave her a pass to continue into the road. She then proceeded straight
 7 and was going to turn left to go west on East Foothill Blvd. As she progressed through the eastbound lanes, she felt an
 8 impact to the rear of her vehicle. Barrios stated she believed the officer was on her cell phone. I asked Barrios if she saw
 9 a cell phone in the officer's hand, and she stated no. Barrios confirmed she observed the officer looking down prior to
 10 entering the roadway. Driver #2 requested medical aid for a complaint of pain and transported to ARMC. Vehicle #2
 11 was moved to a nearby parking lot.

12
 13 **VIDEO SURVEILLANCE:**

14
 15 I made contact with Rialto Tire Shop, located at 409 East Foothill Blvd. I spoke with Manager Javier Ledesma reference
 16 any video surveillance from exterior cameras that may have captured the collision. Ledesma searched and located footage
 17 of the collision. A copy of the video was emailed to me. I then made a copy of the video and tagged it into the SBPD
 18 Evidence Locker (Tag #2024-9211).

19
 20 I reviewed the video surveillance. The time stamp is behind one hour, from real time. At 06:20:55, Vehicle #2 is seen
 21 waiting to exit the private parking lot, with the left turn signal activated. Several eastbound vehicles slow down and come
 22 to a stop in the #1 eastbound lane. At 06:21:13, Vehicle #1 comes into view and comes to a stop in the #1 eastbound lane,
 23 approximately 100 feet west of the driveway, where Vehicle #2 is located. As traffic begins to move eastbound, Vehicle
 24 #1 stays stopped for about 5 seconds, then slowly proceeds eastbound. At the same time, Vehicle #2 waits for vehicles to
 25 clear and proceeds to enter the roadway to make a left turn. Vehicle #2 is within the #2 lane of the roadway, when Vehicle
 26 #1 continues eastbound and does not yield to Vehicle #2, resulting in the front of Vehicle #1 colliding with the rear driver
 27 side of Vehicle #2.

28
 29 **PHOTOGRAPHS:**

30
 31 Photographs of the vehicles, driver's and collision scene were taken by Rialto PD, prior to moving the vehicles out of the
 32 roadway. The photographs were emailed to me. I then made a copy of the photographs and tagged them into the SBPD
 33 Evidence Locker (Tag #2024-9211)

PREPARER'S NAME	I.D. NUMBER	DATE	REVIEWER'S NAME	DATE
A. Mata	50772	09/04/2024		

NARRATIVE/SUPPLEMENTAL

DATE OF INCIDENT	TIME	NCIC NUMBER	OFFICER I.D.	REPORT NUMBER
08/22/2024	0739	3610	50772	2024-99849

SUMMARY:

Driver #1 was on-duty and driving a marked police vehicle. She was traveling eastbound in the #2 lane of East Foothill Blvd. She stopped, due to slowed traffic from roadway construction. Driver #1 looked away from the roadway and proceeded straight. At the same time, Driver #2 observed the police vehicle stopped, allowing several feet of space to the front of the police vehicle. Driver #2 entered the roadway to make a left turn, while Driver #1 was faced with a large glare from the sunlight. The front of Vehicle #1 collided with the rear driver side of Vehicle #2.

AREA OF IMPACT:

The area of impact was determined by Rialto PD officers at the scene. The area of impact where the front of V1 collided with the rear driver side of V2 is approximately 520 feet west of the west curb line prolongation of North Acacia Avenue and 21 feet north of the south curb line of East Foothill Blvd.

CAUSE:

The cause of this collision was determined through the statements of the involved parties, and video evidence located. The investigation therefore determined that Driver #1 (Duque) was the cause of this collision by violating the following section of the California Vehicle Code 21804(b) – Right-of-Way, which states:

A driver having yielded to traffic may proceed to enter or cross the highway, and the drivers of all other vehicles approaching on the highway shall yield the right-of-way to the vehicle entering or crossing the intersection.

RECOMMENDATION:

None.

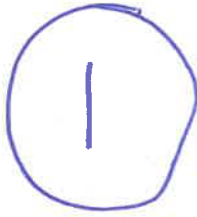
PREPARER'S NAME	I.D. NUMBER	DATE	REVIEWER'S NAME	DATE
A. Mata	50772	09/04/2024		



P.O. BOX 70000
VAN NUYS, CA 91470-0001

EXPLANATION OF BENEFITS

024452



MAIDA BARRIOS

ISSUE DATE	PAGE	E038586
September 14, 2024	00001 OF 00003	

Subscriber's Name: MAIDA BARRIOS
 Identification Number:
 Group Number: DB250I
 Group Name: CALPERS PERS GOLD
 ACTIVES(PA) REGION3
 Medical Plan
 Product:

32

013737020101

Patient's Name: MAIDA BARRIOS	Sequence Number: 1306899166	202400274
Claim Number:	Provider of Services: CALIFORNIA EMERGENCY PHYS	
Claim Processed Date: 09/11/24	Place of Service: Outpatient	
	Patient Acct. Number: E8000121450901	

Paid Amount: \$179.10 To: CALIFORNIA EMERGENCY PHYS
 It is your responsibility to pay: \$340.17 It is not your responsibility to pay: \$704.73

Thank you for using a Network Participating Provider.

SERVICE DATE(S)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/22/24	Emergency Service	1,224.00		704.73/01	295.39/02	44.78/03	179.10
TOTAL THIS CLAIM		1,224.00	0.00	704.73	295.39	44.78	179.10

Patient's Name: MAIDA BARRIOS	Sequence Number: 1306899166	202400274
Claim Number:	Provider of Services: CALIFORNIA EMERGENCY PHYS	
Claim Processed Date: 09/11/24	Place of Service: Outpatient	
	Patient Acct. Number: E8000121586001	

Paid Amount: \$415.42 To: CALIFORNIA EMERGENCY PHYS
 It is your responsibility to pay: \$103.85 It is not your responsibility to pay: \$704.73

Thank you for using a Network Participating Provider.

SERVICE DATE(S)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/27/24	Emergency Service	1,224.00		704.73/01		103.85/03	415.42
TOTAL THIS CLAIM		1,224.00	0.00	704.73	0.00	103.85	415.42

Member's Medical Deductible Applied to Date: \$500.00

THIS IS NOT A BILL

CAEAP518 COMS 20240160420

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE	E038586
September 14, 2024	00002 OF	00003

Subscriber's Name: MAIDA BARRIOS
Identification Number:
Group Number: DB250I
Group Name: CALPERS PERS GOLD
ACTIVES(PA) REGION3
Product: Medical Plan

DETAIL MESSAGE:

- 01 - This is the amount in excess of the maximum allowed amount for a participating provider. The member, therefore, is not responsible for this amount.
- 02 - We applied this amount to your deductible. Your deductible is the amount you pay for health care before we start sharing the costs.
- 03 - This is your share of the cost (coinsurance).

HAVE QUESTIONS??

Check out our Website at www.anthem.com/ca/calpers
Order I.D. Cards / Check claims status / Review benefits /
Verify family members covered on your policy / Find a participating provider
OR call our CUSTOMER SERVICE DEPARTMENT AT: 1-877-737-7776

MAIL ALL INQUIRIES : ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE CO
OR CLAIMS TO : P.O. BOX 60007
LOS ANGELES, CA 90060-0007

WE SUGGEST THAT YOU RETAIN THIS COPY FOR YOUR INCOME TAX RECORDS.

THIS IS NOT A BILL



P.O. BOX 70000
VAN NUYS, CA 91470-0001

EXPLANATION OF BENEFITS

024871

2

ISSUE DATE	PAGE	E038669
September 7, 2024	00001 OF 00003	

Subscriber's Name: MAIDA BARRIOS
 Identification Number:
 Group Number: DB250I
 Group Name: CALPERS PERS GOLD
 ACTIVES(PA) REGION3
 Medical Plan
 Product:



*****ALL FOR AADC 923
 9841 1 AB 0.593 32
 MAIDA BARRIOS

1010201765101

Patient's Name: MAIDA BARRIOS	Sequence Number: 1023113172	202400028
Claim Number:	Provider of Services: ARROWHEAD RADIOLOGY MEDIC	
Claim Processed Date: 09/04/24	Place of Service: Outpatient	
	Patient Acct. Number: 1361810625	

Paid Amount: \$0.00

It is your responsibility to pay: \$204.61 It is not your responsibility to pay: \$582.39

Thank you for using a Network Participating Provider.

SERVICE DATE(s)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/22/24	Radiology-Extremity	50.00		31.82/01	18.18/02		0.00
08/22/24	CT Scan-Head/Neck	124.00		88.48/01	35.52/02		0.00
08/22/24	CT Scan-Head/Neck	124.00		88.48/01	35.52/02		0.00
08/22/24	Radiology-Spine	31.00		19.20/01	11.80/02		0.00
08/22/24	Radiology-Spine	31.00		19.20/01	11.80/02		0.00
08/22/24	CT Scan-Spine	168.00		116.92/01	51.08/02		0.00
08/22/24	CT Scan-Spine	168.00		168.00/03			0.00
08/27/24	Radiology-Extremity	30.00		15.65/01	14.35/02		0.00
08/27/24	Radiology-Extremity	30.00		15.65/01	14.35/02		0.00

THIS IS NOT A BILL

CAEAP518 COMS 20240917B01 J39C

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE	E038669
September 7, 2024	00002 OF 00003	

Subscriber's Name: MAIDA BARRIOS
Identification Number:
Group Number: DB250I
Group Name: CALPERS PERS GOLD
ACTIVES(PA) REGION3
Product: Medical Plan

SERVICE DATE(s)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/27/24	Radiology-Spine	31.00		18.99/01	12.01/02		0.00
TOTAL THIS CLAIM		787.00	0.00	582.39	204.61	0.00	0.00

Member's Medical Deductible Applied to Date:	\$204.61
--	----------

DETAIL MESSAGE:

- 01 - This is the amount in excess of the maximum allowed amount for a participating provider. The member, therefore, is not responsible for this amount.
- 02 - We applied this amount to your deductible. Your deductible is the amount you pay for health care before we start sharing the costs.
- 03 - The doctor/facility billed for this care more times than our guidelines allow. Therefore, the member's plan doesn't pay for it. The member might be responsible for this amount if they chose to receive care from a doctor/facility not in their plan's network.

HAVE QUESTIONS??

Check out our Website at www.anthem.com/ca/calpers
Order I.D. Cards / Check claims status / Review benefits /
Verify family members covered on your policy / Find a participating provider
OR call our CUSTOMER SERVICE DEPARTMENT AT: 1-877-737-7776

MAIL ALL INQUIRIES : ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE CO
OR CLAIMS TO : P.O. BOX 60007
LOS ANGELES, CA 90060-0007

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THIS IS NOT A BILL

CITY OF RIALTO AMBULANCE SERVICE
 PO BOX 269110
 SACRAMENTO, CA 95826-9110
 (800) 906-6552



Customer Invoice

Printed on 11/13/2024

Customer Information	Service Information
BARRIOS, MAIDA	Date/Time of Service: 08/22/2024 / 07:29:06 Run Number: 24-659270 Incident Number: 24-209297 Location: 409 E FOOTHILL BLVD Facility: ARROWHEAD REGIONAL MEDICAL CENTER Address: 400 N PEPPER AVENUE Primary Payor: MERCURY AUTO INSURANCE/10730

Charge Description	Quantity	Unit Price	Amount
Advanced Ambulance Service	1.00	\$1,579.25	\$1,579.25
Mileage	3.00	\$25.40	\$76.20
Total Charges:			\$1,655.45

Credit Description	Payor	Check #	Transaction Date	Amount
No Credits Processed				
Total Credits:				\$0.00

PLEASE PAY THIS AMOUNT: \$1,655.45

DETACH ALONG THE ABOVE LINE AND RETURN STUB WITH YOUR PAYMENT. THANK YOU.

Patient Name: BARRIOS, MAIDA
Run Number: 24-659270
Incident Number: 24-209297
Today's Date: 11/13/2024

Amount Enclosed:
 \$

Remit Payment To: CITY OF RIALTO AMBULANCE SERVICE
 PO BOX 269110
 SACRAMENTO, CA 95826-9110



P.O. BOX 70000
VAN NUYS, CA 91470-0001

EXPLANATION OF BENEFITS

026348

ISSUE DATE	PAGE	E043502
September 30, 2024	00001 OF 00003	

Subscriber's Name: MAIDA BARRIOS
 Identification Number:
 Group Number: DB2501
 Group Name: CALPERS PERS GOLD
 ACTIVES(PA) REGION3
 Medical Plan
 Product:

*****ALL FOR AADC 923
 1876 1 AB 0.593
 MAIDA BARRIOS

4

014752030101

Patient's Name: MAIDA BARRIOS	Sequence Number: 1558410217	202400064
Claim Number: 24257CM8500	Provider of Services: ARROWHEAD REGIONAL MEDICA	
Claim Processed Date: 09/27/24	Place of Service: Outpatient	
	Patient Acct. Number: H100145602600	
Paid Amount: \$2,326.38	To: ARROWHEAD REGIONAL MEDICA	
It is your responsibility to pay: \$6,321.83		

SERVICE DATE(s)	TYPE OF SERVICE	TOTAL BILLED	OTHER AMOUNT(S)	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
08/22/24	MEDICAL SERVICES	8,648.21	5,673.22/03			598.61/01 50.00/02	2,326.38
TOTAL THIS CLAIM		8,648.21	5,673.22	0.00	0.00	648.61	2,326.38*

Member's Medical Deductible Applied to Date:	\$500.00
--	----------

DETAIL MESSAGE:

01 - This is your share of the cost (coinsurance).
 02 - This is your emergency room copay. If you didn't pay it at the time you got care, the hospital may bill you for it.
 03 - We covered this claim based on the amount your plan allows for this care. Your doctor/facility charged more than the allowed amount. You may receive a bill for the difference between the two amounts.
 * If you need care for a non-emergency condition, you can save time and money by using an urgent care center instead of the emergency room. Use our mobile app or log in to our website to find an urgent care in your plan's network.
 * All services included in this claim fall under the No Surprises Act. The member is only responsible for their copay, percentage of the cost (coinsurance), and deductible. The doctor/facility can't bill the member for more.

THIS IS NOT A BILL

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE	E043502
September 30, 2024	00002 OF	00003

Subscriber's Name: MAIDA BARRIOS
Identification Number:
Group Number: DB250I
Group Name: CALPERS PERS GOLD
ACTIVES(PA) REGION3
Product: Medical Plan

HAVE QUESTIONS??

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Verify family members covered on your policy / Find a participating provider
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LOS ANGELES, CA 90060-0007

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THIS IS NOT A BILL.



02222



Account Information

CEP AMERICA CALIFORNIA

Tax Id:

Location of Service: ARROWHEAD REGIONAL MED CTR

Rendering Provider: NEWTON, ERNEST, P.A.

Statement Date: 11/04/24

Account #:

Patient Amount Due: \$340.17

MULTIPLE WAYS TO PAY

SCAN FOR MOBILE PAYMENT or to enter your insurance information



Online www.ePayitOnline.com Code ID: VITUBIL2 Access#: 16100790-1-1735



Phone (866) 954-4405, International # (209) 252-0601

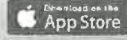


Mail Use the detachable Payment Stub below and enclosed return envelope



Pay with a picture in seconds!

Search Papaya Payments in the App Store or go to www.ppaya.com/pay



Primary Insurance: ANTHEM BLUE CROSS CAREL

Secondary Insurance:

Date of Service	Description of Services	Charges	Payments	Adjustments	Amount Due
08/22/24	99285 EMERGENCY DEPT VISIT HIGH MDM	\$1,224.00			
09/23/24	CARRIER PAYMENT		\$179.10-		
09/23/24	CARRIER ADJUSTMENT			\$704.73-	

THE BALANCE OF THIS ACCOUNT REPRESENTS YOUR CO-PAY, DEDUCTIBLE AND/OR NON-COVERED SERVICES. YOUR ACCOUNT IS 30 DAYS PAST DUE. PLEASE REMIT PAYMENT.

EL SALDO DE ESTA CUENTA REPRESENTA SU COPAGO, DEDUCIBLE O SERVICIOS NO CUBIERTOS. SU CUENTA TIENE 30 DIAS AL COBRO. FAVOR DE REMITIR SU PAGO.

5

FINAL NOTICE

If uninsured or with high medical expenses, you may qualify for a discount, payment plan or Medicaid Program; please contact our office for assistance. If you have insurance, you can submit information via our secure portal at www.epayitonline.com or fill out the back of this form and submit it to billing@vituity.com

Si no tiene seguro medico o tiene gastos medicos altos, puede calificar para un descuento, un plan de pago o un programa de Medicaid; Por favor de comunicarse con nuestra oficina para obtener ayuda. Si tiene seguro medico, puede enviar información a través de nuestro portal seguro www.epayitonline.com o completar el reverso de este formulario y enviarlo a billing@vituity.com

Contact Us

billing@vituity.com or (800) 498-7157 6 am - 5:30 pm PST

AMOUNT DUE

\$340.17

Please detach and return the bottom portion with payment

VITUBIL2-1085053-0000000-16100790-001-001735-#002380-0994

CEP AMERICA CALIFORNIA PO BOX 582663 MODESTO CA 95358-0046



epayitonline.com

Easiest way to view your statement, make payments, set up a payment plan or submit insurance information

STATEMENT DATE	ACCOUNT #	AMOUNT DUE
11/04/24	E80 1214509	\$340.17

Patient: MAIDA BARRIOS

Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

MAKE CHECK PAYABLE AND REMIT TO:



02222

MAIDA BARRIOS



CEP AMERICA CALIFORNIA PO BOX 582663 MODESTO CA 95358-0046

11042400000034017E80001214509



This is not a bill. This is an itemization of hospital services for:

Patient: Barrios, Maida

Hospital Account: 1001465013

Guarantor: Barrios, Maida

Admission Date: 08/27/24

Discharge Date: 08/27/24

Address:

Coverage(s): Blue Cross Blue Shield - BCBS



Charges

Svc Dt	Rev Code	CPT(R)/HCPCS Code	Description	Qty	Amount
08/27/2024	0260	96372	HC INJECTION, THERAP/PROPH/DIAGNOST, IM OR SUBCUT	1	207.00
08/27/2024	0320	72100	HC X-RAY LUMBAR SPINE 2/3 VW - XR LUMBAR SPINE 2-3 VIEWS	1	402.00
08/27/2024	0320	73502	HC X-RAY EXAM HIP UNI 2-3 VIEWS - XR HIP 2 OR 3 VW LEFT	1	402.00
08/27/2024	0320	73552	HC RADIOLOGIC EXAMINATION FEMUR MINIMUM 2 VIEWS - XR FEMUR 2+ VW LT	1	402.00
08/27/2024	0450	99283	HC EMERGENCY DEPARTMENT LEVEL 3 VISIT MODERATE SEVERITY	1	1,433.00
08/27/2024	0636	J1885	KETOROLAC PER 15 MG	2	26.00
08/27/2024	0637		METHOCARBAMOL 500 MG TABLET	1	3.60

Total charges: 2,875.60

Payments and Adjustments

Date	Description	Amount
11/30/24	Blue Cross Blue Shield Payments Non-covered: 2,261.75	-613.85
09/24/24	Blue Cross Blue Shield Adjustments	-790.78

Total payments and adjustments: -1,404.63

Current Hospital Account Balance: 1,470.97

Questions? Call: (877)818-0672 or **Email:** Patientaccounts@armc.sbcounty.gov
Customer service representatives are available
Monday - Friday 8:30 AM to 4:00 PM (except holidays).



This is not a bill. This is an itemization of hospital services for:

Patient: Barrios, Maida
 Guarantor: Barrios, Maida
 Address:

Hospital Account: 1001456026
 Admission Date: 08/22/24
 Discharge Date: 08/22/24

Coverage(s): Blue Cross Blue Shield - BCBS

Charges

Svc Dt	Rev Code	CPT(R)/HCPCS Code	Description	Qty	Amount
08/22/2024	0320	72072	HC X-RAY THORACIC SPINE+SWIM 3 VW - XR THORACIC SPINE 3 VIEWS	1	402.00
08/22/2024	0320	73130	HC X-RAY HAND 3+ VW - XR HAND 3+ VIEWS LEFT	1	402.00
08/22/2024	0351	70450	HC CT SCAN, HEAD/BRAIN, W/O CONTRAST MATL - CT HEAD WO CONTRAST	1	3,202.00
08/22/2024	0351	G1004	HC RADIOLOGY CLINICAL DECISION SUPPORT MECHANISM - NATIONAL DECISION SUPPORT COMPANY	1	0.01
08/22/2024	0352	72125	HC CT SCAN, CERVICAL SPINE, W/O CONTRAST - CT CERVICAL SPINE WO CONTRAST	1	3,202.00
08/22/2024	0450	99283	HC EMERGENCY DEPARTMENT LEVEL 3 VISIT MODERATE SEVERITY	1	1,433.00
08/22/2024	0637		HYDROCODONE-ACETAMINOPHEN 5-325 MG TABLET	1	3.60
08/22/2024	0637		METHOCARBAMOL 750 MG TABLET	1	3.60
Total charges:					8,648.21

Payments and Adjustments

Date	Description	Amount
12/12/24	Blue Cross Blue Shield Payments Non-covered: 6,321.83	-2,326.38
09/13/24	Blue Cross Blue Shield Adjustments	-2,378.25
Total payments and adjustments:		-4,704.63

Current Hospital Account Balance: 3,943.58

Questions? Call: (877)818-0672 or **Email:** Patientaccounts@armc.sbcounty.gov
 Customer service representatives are available
 Monday - Friday 8:30 AM to 4:00 PM (except holidays).

THIS IS YOUR DIRECT DEPOSIT RECEIPT

33726937

08/22/24

Amount

\$294.77

8

Two Hundred Ninety-Four and 77/100 Dollars-----

00878 010

MAIDA BARRIOS

Rainbow USA, Inc
BARRIOS, MAIDA

Pay Period: 08/11/2024 - 08/17/2024 26937
SSN: XXX-XX-9818 Employee Number: XXXXX9818

Wages	Hours	Rate	Amount	YTD Amount	Deductions	Amount	YTD Amount
REGULAR	21.15	16.000	338.40	12977.27	CA		50.49
PTO				208.00	CADI	3.72	145.66
OVERTIME				49.44	FIT	14.03	668.61
RETRO				6.89	MEDE	4.90	192.00
					SSEE	20.98	820.98
Total	21.15		338.40	13241.60			
Taxable Gross			338.40	13241.60			
Net Pay			\$294.77	\$11363.86		43.63	1877.74
ACH PAYROLL				Acct 5632			294.77

Missed work

Address: 1000 Pennsylvania Ave, Brooklyn, NY 11207 (718) 485-3000
Your available PTO is 18.00 hours and accrued PTO is 26.00 hours as of 08/17/2024.

she shouldn't have to use her pay time off for this

9

THIS IS YOUR DIRECT DEPOSIT RECEIPT

33735512

Amount

08/29/24

\$382.47

Three Hundred Eighty-Two and 47/100 Dollars-----
00878 010
MAIDA BARRIOS

Rainbow USA, Inc
BARRIOS, MAIDA

Pay Period: 08/18/2024 - 08/24/2024 35512
SSN: XXX-XX-9818 Employee Number: XXXXX9818

Wages	Hours	Rate	Amount	YTD Amount	Deductions	Amount	YTD Amount
PTO	14.00	16.000	224.00	432.00	CA	2.38	52.87
REGULAR	13.33	16.000	213.28	13190.55	CADI	4.95	150.61
OVERTIME	0.53	24.000	12.72	62.16	FIT	25.77	694.38
RETRO				6.89	MEDE	6.53	198.53
					SSEE	27.90	848.88
Total	27.86		450.00	13691.60			
Taxable Gross			450.00	13691.60			
Net Pay			\$382.47	\$11746.33		67.53	1945.27
ACH PAYROLL				Acct 5632			382.47

Address: 1000 Pennsylvania Ave, Brooklyn, NY 11207 (718) 485-3000
Your available PTO is 5.00 hours and accrued PTO is 27.00 hours as of 08/24/2024.

she shouldn't have to
use her ~~time~~^{Pay} time off for this

Employee Attendance Record With Summaries

Name Barrios, Maida

Hire Date

3/20/2008

10

Start Date	End Date	Cd	Position	Perc	Hrs	Mos	Wrkl
3/20/2008	10/14/2015	CL	Instr Aide/SPED I	75.00%	6	9	DO
10/15/2015	8/13/2017	CL	Instr Aide/SPED I	75.00%	6	9	AD
8/14/2017	8/11/2019	CL	Instr Aide/SPED III	75.00%	6	9	AD
8/12/2019		CL	Instr Aide/SPED III	75.00%	6	9	DHS

2024-2025

Date	End Date	AttCd	SHrs	SBal	VHrs	VBal	Days	DKT
7/1/2024		ADV	+54.00	324.25	+120.00	240.00	20	
8/22/2024	8/23/2024	S	-12.00	312.25			2	
8/26/2024	8/27/2024	S	-12.00	300.25			2	
9/10/2024	9/11/2024	PN	-12.00	288.25			2	
9/19/2024	9/20/2024	PN	-12.00	276.25			2	
10/14/2024		PB					1	1
10/21/2024	10/22/2024	PN	-12.00	264.25			2	
11/7/2024		S	-1.00	263.25			0.167	
11/25/2024	11/27/2024	V			-18.00	222.00	3	
2024-2025 Totals								
	Personal Business	PB					1	
	Personal Necessity	PN	-36.00				6	
	Personal Illness	S	-25.00				4.167	
	Vacation	V			-18.00		3	
	Total		-61.00		-18.00		14.2	

\$ 612.50

She shouldn't have to use her pay time off!