



CONSOLIDATED COMMISSION ON UTILITIES
Guam Power Authority | Guam Waterworks Authority
P.O. Box 2977 Hagatna, Guam 96932 | (671)649-3002 | guamccu.org

RESOLUTION NO. 41-FY2017

**RELATIVE TO APPROVING THE TERMS OF THE PROPOSED SETTLEMENT IN
THE CLAIM AGAINST THE GUAM WATERWORKS AUTHORITY BY
JOSEPH M.M. CRUZ ALSO REFERENCED
AS GWA GOVERNMENT CLAIM NO. 2017-003**

WHEREAS, under 12 G.C.A. § 14105, the Consolidated Commission on Utilities (“CCU”) has plenary authority over financial, contractual and policy matters relative to the Guam Waterworks Authority (“GWA”); and

WHEREAS, the Guam Waterworks Authority (“GWA”) is a Guam Public Corporation established and existing under the laws of Guam; and

WHEREAS, the Government Claims Act 5 G.C.A. §6206 requires approval of the Board for all other claims in excess of Three Thousand Dollars (\$3,000.00), excluding motor vehicle damage and personal injury claims less than \$15,000; and

WHEREAS, on December 30, 2016 manhole number 3634 was surcharging. GWA personnel arrived at approximately 4:30 p.m. to attempt clear the line. Detry Plumbing was then contacted to assist GWA personnel to clear the sewer line of the obstruction later identified as grease and rag buildup. Detry Plumbing utilized a combination truck and jetted the sewer line from manhole number 3638 upstream (approximately 50 feet) where the obstruction was located. As a result of this obstruction, sewage overflowed into the Cruz residence (110 S. San Miguel St. Talofofo Guam) via the two bathrooms in the home causing personal property and real property damage; and

1 **WHEREAS**, on February 22, 2017 Mr. Joseph M.M. Cruz (“Claimant”), one of the legal
2 homeowners of 110 S. San Miguel Street Talofofo, Guam simultaneously filed a claim against
3 GWA in the amount of Five Thousand Sixty One Dollars and Eighty Four Cents (\$5,061.84) *for*
4 *loss of wages* as missed days of work as a result of the sewer overflow into his home, Exhibit
5 “A”; and
6

7 **WHEREAS**, GWA has determined that claimant should be compensated for the loss of
8 wages as a result of the December 30, 2016 sewer overflow totaling Five Thousand Sixty One
9 Dollars and Eighty Four Cents (\$5,061.84) which shall be paid upon signing of the Release &
10 Settlement agreement; and
11

12 **WHEREAS**, GWA has offered as part of the final settlement offer issuance of Three
13 Thousand Dollars (\$3,000.00) before July 16, 2017 to assist the family with initial expenses
14 resulting from the overflow. This amount of \$3,000.00 will be reduced from the Five Thousand
15 Sixty One Dollars and Eighty Four Cents (\$5,061.84).
16

17 **WHEREAS**, GWA believes the proposed settlement and method of payment to be fair
18 and reasonable; and
19

20 **WHEREAS**, the Consolidated Commission on Utilities finds that this proposed
21 settlement is just and reasonable considering the circumstances.
22

23 **NOW THEREFORE, BE IT RESOLVED**, the Consolidated Commission on Utilities
24 does hereby find, authorize and approve the following:
25

- 26
- 27 1. Mr. Joseph M.M. Cruz sustained loss of wages as a result of a sewage over flow into
28 his residence, 110 S. San Miguel Street Talofofo, Guam on December 30, 2016.
 - 29 2. Mr. Joseph M.M. Cruz has provided proof to GWA of the loss of wages (184 of
30 Annual Leave hours) from January 3, 2017 through February 3, 2017 to remove
31 damaged personal property and the relocation of his family (Exhibit A).
 - 32 3. That GWA issue a check in the amount of Three Thousand Dollars (\$3,000.00) as

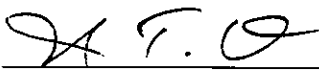
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part of the final settlement offer on or before July 16, 2017 to assist the family with initial expenses.


- 4. That GWA may pay the Claimant an amount of Two Thousand Sixty One Dollars and Eighty Four Cents (\$2,061.84) following the execution of a Release and Settlement Agreement.
- 5. The CCU finds the offer fair and reasonable under the circumstances.
- 6. The GWA GM is authorized to sign all documents necessary to settle the claim as approved by the CCU.

RESOLVED, that the Chairman certifies and Board Secretary attests to the adoption of the Resolution.

DULY AND REGULARLY ADOPTED AND APPROVED this 6th day of July, 2017.

Certified by:


JOSEPH T. DUENAS
 Chairperson

Attested by:


J. GEORGE BAMBA *FRANCIS R. Santos*
 Secretary *Vice-Chair*

I, J. George Bamba, Board Secretary for the Consolidated Commission on Utilities, as evidenced by my signature above do hereby certify as follows:

The foregoing is a full, true and accurate copy of the resolution duly adopted at a regular meeting by the member of the Guam Consolidated Commission on Utilities, duly and legally held at a place properly noticed and advertised at which meeting a quorum was present and the members who were presented voted as follows:

AYES: 4

NAYS: 0

ABSTENTIONS: 0

ABSENT: 1



Office of the Attorney General of Guam

590 S. Marine Corps Dr., Ste. 706, Tamuning, Guam 96913



FILING A CLAIM AGAINST THE GOVERNMENT

Please be advised that under the Government Claims Act (5 G.C.A., Chapter 6), the government has **SIX (06) MONTHS** in which to investigate and either grant, settle, or deny your claim.

If your claim involves a **traffic accident**, you need to submit:

1. A copy of the police report;
2. A copy of the vehicle registration;
3. Two to three estimates of repair from a licensed auto repair shop
4. Pictures of the damages

If your claim involves **wages**, you need to submit:

- Any documents of proof of wages owed.

If your claim involves a **dormant bank account**, you need to submit:

- Account name, account number, address, social security number, and proof of authorized access to account funds.

Please provide **copies** of all documents. We are unable to make copies due to budgetary cuts. If you have any questions, please call our office at 475-3324.

Please read, sign and return the letter on the reverse side of this sheet. Thank you.





Office of the Attorney General of Guam

590 S. Marine Corps Dr., Ste. 706, Tamuning, Guam 96913



Dear Claimant:

Pursuant to the Government Claims Act (Public Law 17-29), the government has six (06) months to investigate and either grant, settle or deny your claim. If you are claiming property damage to a motor vehicle involved in an accident, we will make a determination on this part of your claim within thirty (30) days pursuant to Public Law 25-130, provided you furnish us with all the documents necessary to process your claim.

Although most claims require the full six (06) months for review and final decision, smaller claims usually take less time than larger ones; however, they are considered equally. If after six (06) months your claim has not been settled or you have not been notified by our office that your claim was denied, you may institute an action in the Superior Court of Guam for money damages.

Additional questions on the status of this claim should be directed to the undersigned.

Thank you in advance for your cooperation.

Sincerely,

DONALD V. SAN AGUSTIN
Assistant Claims Officer

I have read and fully understand the above.

Print Name: Joseph M. Cruz

Signature: [Handwritten Signature]

Date: 2/22/17



Office of the Attorney General of Guam

590 S. Marine Corps Dr., Ste. 706, Tamuning, Guam 96913



CLAIM AGAINST THE GOVERNMENT

(Please complete the form in its entirety. **DO NOT** leave any portions blank. Write "N/A" or "None" where appropriate.)

1. Name of Claimant: Joseph MM Cruz
2. Mailing Address: PO Box 3634 Hagatna GU 96932
Home/Work Address: 110 South San Miguel St. Talofofo GU 96915
3. Home Telephone 969-1873/988-3166 Work Telephone 475-6208
4. Amount of Damages you are claiming: \$ 5,061.84
5. Any other relief you are claiming NA
6. Government Agency Responsible GWA Guam Waterworks Authority
7. Date Claim arose Dec. 30, 2016
8. Your statement of facts upon which you base your claim. Attach extra sheet(s) if necessary.
Loss of Home due to raw sewage (Submerged in home)
Please see attachment.
9. Attach a copy of all documents pertaining to your claim, such as a police report, accident report or a contract.
10. The lowest estimate of repair is \$ NA
11. I have the following insurance covering this claim NA
12. I am the real party in interest except for the following parties who have an interest in this claim:
NA
13. I have received the following compensation/repairs from other parties NA
14. Name, address, and telephone of attorney representing claimant, if any:
NA

All notices will be sent to your mailing address above or if you have an attorney, to your attorney's address. If you want to change the address at which you will receive notices, you must file, in writing, a change of address with the Claims Officer.

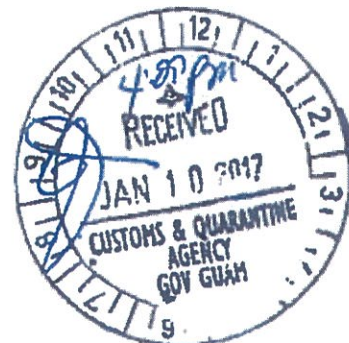
I, Joseph mm Cruz, declare under penalty of perjury that the foregoing is true and correct.
Date 2/22/17 Claimant's Signature [Signature]

LEAVE APPLICATION FORM

COPY

NAME (First, Middle, Last) Joseph M.M. Cruz		SOCIAL SECURITY NO.: 0037	DATE OF REQUEST: 01/06/17
TYPE OF LEAVE REQUESTED <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> SICK <input type="checkbox"/> LEAVE W/O PAY <input type="checkbox"/> COMP-TIME OFF <input type="checkbox"/> TRAINING (LOCAL / OFF-ISLAND) <input type="checkbox"/> OTHER			
LEAVE PERIOD			
FROM (Hour, Month, Day, Year) 0800/// 01/03/17	TO: (Hour, Month, Day, Year) 1700/// 01/06/17	TOTAL HOURS REQUESTED: 32.00	
ADDRESS WHILE ON LEAVE: 110 South San Miguel St. Tafelofa			
APPLICATION FOR PREPAYMENT OF VACATION LEAVE			
Minimum requirement is not less than ten (10) consecutive days. It is understood that if I return to duty before the expiration of my prepaid vacation, I shall reimburse the government in the amount equivalent to the unexpired portion of the prepaid leave.			
FROM (Hour, Month, Day, Year)	TO: (Hour, Month, Day, Year)	TOTAL HOURS PREPAID:	
SICK LEAVE CERTIFICATION			
I certify that the above person was under my professional care or quarantine during the period stated below. From a medical standpoint, his/her condition during this period was such that I considered it inadvisable for him/her to report to work.			
FROM: (Month, Day, Year)	TO: (Month, Day, Year)	TOTAL NO. OF DAYS	
REMARKS:			
NAME OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL (TYPE OR PRINT)		SIGNATURE OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL	
SIGNATURE OF EMPLOYEE <i>Joseph M.M. Cruz</i>			
<input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED Lt. Daniel L. Tajarero, Maritime Supervisor ICD SIGNATURE OF IMMEDIATE SUPERVISOR		<input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED Major Philip S.N. Tajarero Jr., Asst. Chief ICD SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY	
Form ACC-PYC001 Revised 12/2012			

RECEIVED
JAN 11 2017
 DEPT OF ISLANDS
 Terminal Station



GOVERNMENT OF GUAM
LEAVE APPLICATION FORM

NAME (First Middle Last) Joseph M.M. Cruz	SOCIAL SECURITY NO: 0037	DATE OF REQUEST: 01/06/17
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TYPE OF LEAVE REQUESTED
 ANNUAL SICK LEAVE W/O PAY COMP-TIME OFF TRAINING (LOCAL / OFF-ISLAND) OTHER

LEAVE PERIOD		
FROM (Hour Month Day, Year) 0800/// 01/09/17	TO (Hour Month Day, Year) 1700/// 01/20/17	TOTAL HOURS REQUESTED: 72.00

ADDRESS WHILE ON LEAVE: **110 South San Miguel St. Talofofo**

APPLICATION FOR PREPAYMENT OF VACATION LEAVE

Minimum requirement is not less than ten (10) consecutive days. It is understood that if I return to duty before the expiration of my prepaid vacation, I shall reimburse the government in the amount equivalent to the unexpired portion of the prepaid leave.

FROM (Hour, Month, Day, Year)	TO (Hour, Month, Day, Year)	TOTAL HOURS PREPAID:
-------------------------------	-----------------------------	----------------------

SICK LEAVE CERTIFICATION



I certify that the above person was under my professional care or quarantine during the period stated below. From a medical standpoint, his/her condition during this period was such that I considered it inadvisable for him/her to report to work.

FROM: (Month Day Year)	TO: (Month Day Year)	TOTAL NO. OF DAYS:
------------------------	----------------------	--------------------

REMARKS:

NAME OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL (TYPE OR PRINT)	SIGNATURE OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL
--	---

SIGNATURE OF EMPLOYEE:


<input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED  Lt. David B. Paitano, Maritime Supervisor ICD SIGNATURE OF IMMEDIATE SUPERVISOR	<input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED  JAMES T. McDONNELL DIRECTOR, O&A SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY
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LEAVE APPLICATION FORM

NAME (First, Middle, Last) JOSEPH M.M. CRUZ	SOCIAL SECURITY NO.: ██████-0037	DATE OF REQUEST: 01/17/17
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TYPE OF LEAVE REQUESTED
 ANNUAL SICK LEAVE W/O PAY COMP-TIME OFF TRAINING (LOCAL / OFF-ISLAND) OTHER

LEAVE PERIOD		
FROM (Hour, Month, Day, Year) 0800 hours 01/23/17	TO: (Hour, Month, Day, Year) 1700 hours 2/03/17	TOTAL HOURS REQUESTED: 80.00

ADDRESS WHILE ON LEAVE: **110 SOUTH SAN MIGUEL STREET TALOFORO, GU 98915**

APPLICATION FOR PREPAYMENT OF VACATION LEAVE

Minimum requirement is not less than ten (10) consecutive days. It is understood that if I return to duty before the expiration of my prepaid vacation, I shall reimburse the government in the amount equivalent to the unexpired portion of the prepaid leave.

FROM (Hour, Month, Day, Year)	TO: (Hour, Month, Day, Year)	TOTAL HOURS PREPAID:
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SICK LEAVE CERTIFICATION

I certify that the above person was under my professional care or quarantine during the period stated below. From a medical standpoint, his/her condition during this period was such that I considered it inadvisable for him/her to report to work.

FROM: (Month, Day, Year)	TO: (Month, Day, Year)	TOTAL NO. OF DAYS:
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REMARKS:

NAME OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL (TYPE OR PRINT)	SIGNATURE OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL
--	---

SIGNATURE OF EMPLOYEE:

<input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED Lt. David L. Taitano, Supervisor Maritime Section JCD SIGNATURE OF IMMEDIATE SUPERVISOR	<input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED James T. McDonald, Director of CQA SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY
--	--

DEPT OF ADMINISTRATION
Employee Earnings Statement 2/10/2017

Employee number : 12605 Dept 3225
 Employee name : JOSEPH MM GRUZ
 Pay period ending : 2/04/2017 Hourly rate : 27.51

EARNINGS INFORMATION

	----- Hours -----		Current	YTD
	Current	YTD		
Work hours		35.00		
Annual leave			2200.80	962.85
Sick leave				5061.84
Other leave		24.00		660.24
Accrual pay		1.00		2.75
Performance pay				272.35
Merit pay			2200.80	6960.03
Pay declared amount			251.33	750.12
Adjusted gross pay			1949.47	6201.91

TIME OF DEDUCTION

	----- Hours -----		Current	YTD
	Current	YTD		
Annual leave		8.00		24.00
Medical (donated)			80.00	184.00
Life insurance				348.00
Health insurance		4.00		12.00
Life insurance (donated)				
Health insurance (donated)				
Life insurance balance				894.00

EMPLOYEE INFORMATION

Class of

Employee information section containing various fields and values, mostly illegible due to heavy noise and low contrast in the scan.

DEPT OF ADMINISTRATION
Employee Earnings Statement 1/13/2017

Employee number : 12605 Dept : 3223
 Employee name : JOSEPH MM CRUZ
 Pay period ending : 1/07/2017 Hourly rate : 27.51

EARNINGS INFORMATION

	----- Hours -----		Current	YTD
	Current	YTD		
Work hours :	35.00	35.00	962.85	962.85
Annual leave :			880.32	880.32
Sick leave :				
Other leave :	16.00	16.00	440.16	440.16
Premium pay :	1.00	1.00	2.75	2.75
Overtime :				
Retroactive pay :				
Other pay :				
Gross pay :			2286.08	2286.08
Tax deferred amount :			255.46	255.46
Adjusted gross pay :			2030.62	2030.62

LEAVE INFORMATION

	----- Hours -----	
	Current	YTD
Annual Leave		
Accrued :	8.00	8.00
Received (donated) :		
Used :	32.00	32.00
Balance :		484.00
Sick Leave		
Accrued :	4.00	4.00
Received (donated) :		
Used :		
Balance :		894.00
Compensatory time balance :		

WITHHOLDING & DEDUCTION INFORMATION

	Current	YTD
Guam income tax :	109.85	109.85
Social security tax :		
Medicare tax :	31.11	31.11
Defined benefit plan :		
Defined contribution plan :	114.17	114.17
Health insurance :	107.90	107.90
Dental insurance :	32.64	32.64
Life insurance :	4.02	4.02
Statutory withholding total :	399.69	399.69
	<u>Current</u>	<u>YTD</u>
ADMINISTRATIVE SERVICES CORP.	.75	.75
BANK OF GUAM	5.00	5.00
LINCOLN NATIONAL LIFE INS. CO.	101.91	101.91
COAST360 FEDERAL CREDIT UNION	1778.73	1778.73
Total withholding & deductions	2286.08	2286.08

Account

DEPT OF ADMINISTRATION
Employee Earnings Statement 1/13/2017

Employee number : 12605 Dept : 3223
 Employee name : JOSEPH MM CRUZ
 Pay period ending : 1/07/2017 Hourly rate : 27.51

EARNINGS INFORMATION

	----- Hours -----		Current	YTD
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Work hours :	35.00	35.00	962.85	962.85
Annual leave :			880.32	880.32
Sick leave :				
Other leave :	16.00	16.00	440.16	440.16
Premium pay :	1.00	1.00	2.75	2.75
Overtime :				
Retroactive pay :				
Other pay :				
Gross pay			2286.08	2286.08
Tax deferred amount :			255.46	255.46
Adjusted gross pay			2030.62	2030.62

LEAVE INFORMATION

	----- Hours -----	
	Current	YTD
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Accrued :	8.00	8.00
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Used :	32.00	32.00
Balance :		484.00
Sick Leave		
Accrued :	4.00	4.00
Received (donated) :		
Used :		
Balance :		894.00
Compensatory time balance :		

WITHHOLDING & DEDUCTION INFORMATION

	Current	YTD
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ADMINISTRATIVE SERVICES CORP.	.75	.75
BANK OF GUAM	5.00	5.00
LINCOLN NATIONAL LIFE INS. CO.	101.91	101.91
COAST360 FEDERAL CREDIT UNION	1778.73	1778.73
Total withholding & deductions	2286.08	2286.08