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# LAW OFFICES OF BRADLEY J. FRIGON, LLC

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## PERSONAL INJURY INTAKE FORM
## (for First Party Special Needs Trust)

Name: _____

Address: _____

Mailing Address:

_____

Home phone: _____ Work phone: _____

Cell phone: _____ Fax: _____

Email: _____

Preferred way to contact? _____

**This information is extremely important. Your accuracy and completeness in completing this form will assist in our analysis of your case.**

## I. FACTUAL BACKGROUND

1. Plaintiff's Information:

   Name: _____

   Address: _____

   Telephone Number: _____ Marital Status: M _____ S _____

   Social security number: _____ Date of Birth _____

List Plaintiff's Spouse or Partner and any Minor Children. Provide date of birth for any minor children and indicate if children are from current spouse/partner or a previous marriage or relationship:

_____

_____

_____

_____

2. Provide date of accident, the nature of the Plaintiff's injury and basis for the lawsuit.

_____

_____

_____

3. Is the Plaintiff mentally competent? YES _____ NO _____

4. Where does the Plaintiff live (home, public housing, group home, skilled nursing facility)?

_____

_____

5. Who is the Plaintiff's primary care provider: _____

_____

6. U.S. Citizen? Yes ☐ No ☐

7. Veteran? Yes ☐ No ☐

8. Is the Plaintiff represented by an attorney? YES _____ NO _____.

If Yes, identify counsel of record for each party to the lawsuit:

Plaintiff:_____

_____

_____

_____

_____

Defense:_____

_____

_____

_____

_____

Attach separate contact information for each attorney of record and identify the party they represent.

9. List contact information for each structured settlement broker involved in the case.

_____
_____
_____
_____

## II. MEDICAL DATA

1. **Health**

Diagnosis _____
_____

Prognosis _____
_____

Ongoing Expenses. List anticipated ongoing medical expenses, or attach copy of life care plan._____
_____
_____
_____

2. **Health Insurance**

Is the Plaintiff covered under a health insurance policy? Yes ☐ No ☐

If Yes, attach copy of policy or summary of benefits: If a government or military health insurance coverage just indicate type of plan:
_____

What are the conditions for continued coverage or when is coverage expected to cease:
_____

If the Plaintiff is covered under a group health plan, is the Plaintiff's continued coverage under the group plan as a result of a spouse or other family member? Yes ☐ No ☐

If the Plaintiff's coverage is the result of a spouse or other family member, indicate how long the Plaintiff can maintain coverage under the group health plan.
_____
_____
_____
_____

## III. THE SETTLEMENT

1. How much is the overall settlement?_____
2. How much has the Plaintiff received prior to the settlement? _____
3. How is the settlement being paid? _____

   _____

   _____
4. If all or a portion of the settlement is being paid by a structured settlement annuity, provide a summary of the terms of the annuity indicating how much of the annuity payments are guaranteed.

   _____

   _____

   _____
5. What are the costs? _____
6. What is the contingency fee? _____
7 Are fees owed to more than one lawyer? YES _____ NO _____
8. Will there be any attorney liens filed in the case? YES _____ NO _____
9. Indicate if there are any loss of consortium claims, claims for minors or other derivative claims.

   _____
10 If all or part of the settlement has been paid to a trust account, provide the date or dates and amounts the settlement was paid.

   _____
11. Indicate if there has been any allocation of damages:

    _____

    _____

## IV. LIENS AND/OR SUBROGATION CLAIMS

1. Has Medicaid or Medicare been notified of the settlement? YES _____ NO _____
   If yes, please attach a copy of the notification and any other correspondence.
2. Is there a Medicaid lien or Medicare claim? YES _____ NO _____

If yes, please attach a copy of the claim and state if all or part of the lien or claim has been paid.

3. Are there any insurance subrogation claims in the case? YES _____ NO _____

If yes, how much and to whom?

_____

_____

## V. PROTECTIVE PROCEEDINGS

1. Has a conservator, guardian or guardian ad litem been appointed? YES ___ NO ___

If yes, please attach a copy of Order.

## VI. PUBLIC BENEFITS

1. Is the Plaintiff or **anyone** in the Plaintiff's household or immediate family receiving public benefits? YES _____ NO _____.

If yes, what public benefits? _____

2. Is the Plaintiff eligible for Medicare? YES _____ NO _____

If yes, since when? _____

3. If Plaintiff is not eligible for Medicare, has the Plaintiff filed for SSDI? YES ___ NO____

If yes, specify date Plaintiff first received SSDI. _____

4. What public benefits is the Plaintiff receiving? (Please list <u>all</u> public benefits; i.e., Medicaid, special waiver programs, SSI, SSDI, Food Stamps, TANF Medicare, etc.)

_____

_____

5. Is the Plaintiff currently residing in government subsidized housing? YES ___ NO ___
6. Is it likely Plaintiff will require public benefits assistance in the future? YES __ NO __
7. Does the Plaintiff have any other income? YES _____ NO _____

If yes, from what source? _____

8. Does the Plaintiff have any other assets? YES _____ NO _____

If yes, please identify? _____

9. Has someone made an application for public benefits that is still pending?

YES _____ NO _____

## VII. MISCELLANEOUS

1. What does the Plaintiff hope to achieve with this settlement.

_____
_____
_____
_____
_____
_____

2. What kinds of services does the Plaintiff now need that he or she is not receiving?

_____
_____
_____
_____

3. What kinds of equipment or personal property (vehicle, specialized medical equipment, etc) does the Plaintiff hope to purchase with this settlement?

_____
_____
_____

4. Does the Plaintiff want to purchase a home: Yes _____ No _____

   If Yes, how much is the purchase price:_____

5. Do you have any other legal issues which I should be aware of? Yes _____ No _____

   If yes, please explain:

_____
_____
_____
_____

## IX. ATTACHMENTS

If available, please attach copies of the following documents to this form

(e) Attach copies of all pending applications for public benefits.

(f) Attach a copy of Medicaid Card or other Public Assistance Identification Card.

(g) Health Insurance policy or summary of benefits.

(h) Life Care Plan.

(i) Rate Age

(j) A copy of the complaint or demand for damages:

(k) Proposed Settlement Agreement:

## X. REFERRAL

By Whom Were You Referred To This Office?
Name_____
Street Address_____
City_____ State_____
Zip_____

**NO ATTORNEY CLIENT RELATIONSHIP IS CREATED UNTIL A FEE AGREEMENT IS SIGNED BY THE CLIENT.**

## XI. CERTIFICATION

The undersigned hereby represents to the LAW OFFICES OF BRADLEY J. FRIGON, and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Plaintiff or Plaintiff's Representative:

DATE: _____ _____