

INTAKE FOR WORKERS' COMPENSATION SETTLEMENTS

I. Factual Background

1. What is the claimant's:

Name: _____

Address: _____

Telephone Number: _____ Marital Status: M _____ S _____

Social security number: _____ Date of Birth _____

List Claimant's Minor Children: _____

2. What was the date of the injury? _____

3. In which state did the injury occur? _____

4. How did the injury occur? _____

5. Has the claimant reached maximum medical improvement? YES _____ NO _____

If YES, attach original letter from Doctor stating maximum medical improvement. If NO, list anticipated date and describe how the claimant is doing today. _____

6. Does the claimant have a rated age? YES _____ NO _____. If YES, attach statement from life insurance company.

7. Is the claimant mentally competent to enter into a settlement? YES _____ NO _____

8. Is there more than one claimant? YES _____ NO _____

If yes, list names of additional claimant(s) and nature of claims.

9. Where does the claimant live (home, public housing, group home, skilled nursing facility)? _____
_____.
10. Indicate if the claimant is permanent partial disability, permanent total disability, combination of both or not applicable. (Circle One).

II. The Settlement

1. How much is the overall settlement? _____.
2. How much has the claimant received prior to the settlement? _____.
3. Indicate if payments for medical expenses are based upon a worker compensation fee schedule, actual charge amount or not applicable. (Circle One).
4. How is the settlement being paid? _____
5. If all or a portion of the settlement is being paid by a structured settlement annuity, provide the cost of the annuity, and the terms of the annuity indicating how much of the annuity payments are guaranteed. _____

_____.
6. What are the costs? _____
7. What is the contingency fee? _____
8. Are fees owed to more than one lawyer? YES _____ NO _____
9. Will there be any attorney liens filed in the case? YES _____ NO _____
10. Provide details on how much of the settlement is being apportioned to indemnity and how much is being apportioned to future or past medicals _____

_____.

10. Is the amount of the settlement for future medicals based upon actual costs or based upon the workers' compensation fee schedule amounts? _____
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III. 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.

2. Is there a Medicaid lien or Medicare claim? YES _____ NO _____

If yes, please attach a copy of the claim.

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

If yes, how much and to whom? _____

IV. Protective Proceedings

1. Has a conservator, guardian or guardian ad litem been appointed?

YES _____ NO _____

If yes, please attach a copy.

V. Public Benefits

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

If yes, what public benefits? _____

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

If yes, since when? _____.

3. State whether eligibility for Medicare is based upon age, disability or End Stage Renal Disease. (Circle One).

If already eligible, please attach copy of Medicare Card.

4. If Claimant is not eligible for Medicare, has the claimant filed for SSD? YES _____

NO _____. If YES, specify date claimant first received SSD. _____

5. What public benefits is the claimant receiving? (Please list all public benefits; i.e., Medicaid, special waiver programs, SSI, SSDI, Medicare, etc.) _____

6. Is it likely the claimant will require public benefits assistance in the future?
YES _____ NO _____

7. Does the claimant have any income? YES _____ NO _____
If yes, from what source? _____

8. Has someone made an application for public benefits that is still pending?
YES _____ NO _____

8. In 18 states plus the District of Columbia, the carrier takes the offset in Worker's Compensation cases and the claimant's Social Security will not be affected by the settlement. In the remaining states, the settlement could cause the claimant to lose his or her Social Security entirely if the monies apportioned to indemnify are not carefully thought through before being apportioned. Who will be advising the claimant concerning the offset for Social Security Disability? _____

VI. Miscellaneous

1. List the name and address of insurance company, claim adjuster and provide the claim number for this case. _____

2. Provide the name and address of the attorney for insurance carrier/claimant. _____

ATTACHMENTS

Please attach copies of the following documents to this form

1. Copy of Compromise and Release or proposed Compromise and Release if not finalized.
2. A print out showing past medical expenditures by the carrier since the date of the injury is attached.
3. A sheet defining the print out codes to classify the type of each expenditure.

4. The claimant's official life expectancy or rated age statement from a life underwriter or a structured settlement specialist or a life care planner or a physician.
5. Life Care Plan(s). If no Life Care plan is available, copies of letters from Doctors and other medical providers that document the necessity of future care.
6. A recent medical report stating that the claimant is at maximum medical improvement for accident-related injuries is attached.
7. Administrative Law Judge Order.
8. Structured Settlement Proposal that shows the actual cost to fund the structure and the terms of the structure.

VII. REFERRAL

By Whom Were You Referred To This Office?

Name _____
Street Address _____
City _____ State _____
Zip _____

VIII. CERTIFICATION

The undersigned hereby represents to the _____ 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 Client or Client Representative:

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
 HEALTH CARE FINANCING ADMINISTRATION

NAME (Print or Type) (Client Name)	H.I. CLAIM NUMBER (Social Security Number)
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SECTION I APPOINTMENT OF REPRESENTATIVE

I appoint this individual: _____, Esq., of _____, to act as my representative in connection with my claim or asserted right under Titles XI, or XVIII of the Social Security Act. I authorize this individual to make or give any request or notice; to present or elicit evidence; to obtain information; and to receive any notice in connection with my claim wholly in my stead.

SIGNATURE (Beneficiary)	ADDRESS
TELEPHONE NUMBER (Area Code)	DATE

Section II ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration or the Health Care Financing Administration; that I am not, as a current or former officer or employee of the United States; disqualified from acting as the claimant's representative; and that I will not charge or receive any fee for the representation until it has been authorized in accordance with the laws and regulations referred to on the reverse side hereof. In the event I decide not to charge or collect a fee for the representation I will notify the Social Security Administration and the Health Care Financing Administration (completion of Section III (optional) satisfies this requirement).

SIGNATURE (Representative)	ADDRESS
TELEPHONE NUMBER (Area Code)	DATE

Section III (Optional) WAIVER OF FEE OR DIRECT PAYMENT

(Note to Representative: You may use this portion of the form to waive a fee or to waive direct payment of the fees from withheld past-due benefits.)

I waive my right to charge and collect a fee for representing before the Social Security Administration or Health Care Financing Administration.

SIGNATURE	DATE
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(See important information on reverse)

CONFORMS IN SUBSTANCE WITH FORM HCFA-1696-U4 (10-84)

