SETTLEMENT DOCUMENT REQUEST WORKSHEET

This worksheet supplies important information necessary for the proper preparation of workers' compensation settlement documents including evaluation of potential Social Security offset or Medicare Set-aside issues related to the concurrent receipt of lump sum or periodic workers' compensation proceeds and certain collateral benefits such as Social Security Disability, Supplemental Security Income, Medicare, Medicaid, federal or state cash assistance or medical benefits, or public or private pension plan benefits. *Incomplete or inaccurate information will delay preparation of the final documents and may cause inaccurate assumptions to be formed and relied upon.*

Title XVI Supplemental Security Income and/or Medicaid recipients require Special Needs Trust consideration is *not* a service provided directly by Angelo Paul Sevarino, Esq. Should a Special Needs Trust be required my office coordinates the preparation of all necessary documents. Additional information and authorizations will be sent upon request.

While every effort is made to mitigate any adverse impact to the recipient due to receipt of concurrent workers' compensation periodic or lump sum benefits and those collateral benefits as outlined above there are *no guarantees* that the Social Security Administration, the Centers for Medicare & Medicaid Services (except in the case of a submission to CMS by Attorney Sevarino), the Department of Administrative Services or Department of Social Services or any other public or private group health, disability or pension plan administrator will accept the assumptions made by Angelo Paul Sevarino, Esq. in the preparation of the settlement documents based upon the information provided by the submitting attorney or party.

Angelo Paul Sevarino, Esq. makes no warranties or representations as to the ultimate rulings as may result from any of these entities' interpretation of the language contained in the settlement document(s). Until such time as the individual entities or their administrator(s) render a final approval of the settlement can the practitioner be assured of the ultimate impact the settlement will have on any collateral benefits received by the client.

Normal turn-around time is 10 business days from receipt of the completed request. The charge for preparation of the settlement document and supporting Notice of Consequences of Your Settlement and Medical Informed Consent forms is $975.00. This fee does not include MSA, MSPRC, CMS referral of SSA request for information. If you need information regarding any of these additional services or fees please refer to the links below.

For additional service and fee information click the appropriate tab:

1. Medicare Set-aside analysis. To learn more about Medicare Set-asides or to request this service please review MSA Request

2. Medicare Conditional Payment Search/Reconciliation. To learn more about Medicare conditional payment investigation and reconciliation or to request this service please review MSPRC Request

3. CMS Referral Request. To learn more about CMS review thresholds and the referral process or to request this service please review CMS Request

All fees are the responsibility of the Submitting party and are not contingent upon any contractual relationship between the submitting party and client/principal or ultimate approval of settlement.

All fees are due and payable 30 days from receipt of invoice or receipt of settlement proceeds whichever is earlier. Interest of 1.5% per month is charged for all outstanding invoices.

The submitting attorney or party warrants to Angelo Paul Sevarino, Esq. that s/he has explained to his or her client that (a) no attorney-client relationship is being established between their client or principal and Angelo Paul Sevarino, Esq., and (b) their client consents to Angelo Paul Sevarino, Esq. reviewing the submitted documents and communicating with the Social Security Administration or The Centers for Medicare & Medicaid Services as may be required. Further, the Submitting attorney or party warrants to Angelo Paul Sevarino, Esq. the accuracy of all the information contained herein.

□ I understand the fee for this service is $975.00. Additional services requested are billed in addition to the $975.00 fee. Once the settlement documents have been released Attorney Sevarino reserves the right to bill for additional revisions. Additional fees will be discussed in advance of preparation of any revisions.

□ I have signed the attached HIPAA medical authorization

The completed settlement documents will be returned to you by first class mail. If FedEx requested check below an additional $35.00 charge will be added to your invoice.

□ I wish the documents transmitted by FedEx

The signatures of submitting attorney/party and Client are <u>required before</u> the settlement documents may be prepared.

_____ _____

Client **Submitting Attorney/Party**

Thank you for allowing me to be of service. Should you have any questions regarding your submission please do not hesitate to contact me.

Angelo Paul Sevarino, Esq.

WORKSHEET

A. Client Information:

1. Full Name:
2. Address:
3. Date of Birth:
4. Race:
5. Sex:
6. Social Security No:
7. Spouse's name:
   Date of Birth:
   Date of Marriage to the Client:

8. Is the Client's spouse or other dependent(s) collecting *any* Social Security, cash assistance, or medical aid assistance benefits from *any* Federal or State program or other private/public pension or private/public disability benefits? *If so, describe fully and document with plan booklets or benefit recap*.

9. Name(s) and date(s) of birth of the dependent child(ren) of the Client (indicate if any child is not the issue of the marriage to the above named spouse and if so if the Client is currently eligible to claim said child(ren) as an exemption on his or her Federal tax return):

B. Name and Address of Employer(s) (on date of injury or at time of onset of disability). Indicate any periods of concurrent employment and who the concurrent employer(s) are/were:

C. Name and Address of Insurer(s)/Administrator(s):
(If multiple employers indicate applicable insurer/administrator

D. Second Injury Fund. If Second Injury Fund involvement, indicate under what statutory provision the Fund's liability results from and date liability was assumed. If transferred under C.G.S. 31-349 indicate the effective transfer date. *Attach a copy of the transfer agreement or other Order*.

E. Accident Case Information:

1. Date(s) of Injury/Illness: (if more than one injury or illness indicate, onset date for each, body part(s)/system(s) involved and which insurance carrier(s), including Second Injury Fund, if applicable, apply to each).

2. Workers' Compensation District:
3. WCC District File No:
4. Name and address of all opposing counsel (identify party represented or pro-se parties).

5. Specific description of how injury(s) or illness(es) occurred or manifested.

6. Body part(s)/system(s) involved (please be specific).

7. For each injury or illness, indicate period(s) of temporary total or temporary partial disability, permanent partial impairment, if applicable, indicate date of maximum medical improvement, if applicable, for <u>each</u> body part/system, the rating for <u>each</u> body part/system, and the physician's name who established the rating.

8. Indicate:

Client's average weekly wage	$_____
Client's base workers' compensation rate	$_____
Client's *current* workers' compensation rate including COLAs	$_____

9. List and attach all voluntary agreements, any proposed Stipulation, Form 43/36 or other Commissioner Findings or Orders.

10. Has or will the Client undergo a program of vocational rehabilitation?

□ No
□ Yes, explain. Is there any cost associated with this incurred or to be incurred by the Client? If so, is this cost included in the settlement value?

11. Are there any accident related *unreimbursed* medical expenses still outstanding? Indicate if they are *included* or *to* be paid *in addition to* the settlement amount.

12. Does the Client's require any retrofitting of the residence or other special equipment due to accident related disability or impairment?

□ No
□ Yes, provide complete details and estimated costs.

13. Will the Client have future medical services or prescription drug therapy expenses?

□ No
□ Yes, if a Medicare Set-aside is *not* being requested please provide your medical cost projections over the life of the Claimant that includes medical services, as well as, prescription drug therapy charges.

F. Social Security/Federal or State cash assistance Information:

1. Is the Client now receiving, or has the Client received in the past, Social Security disability, Supplemental Security Income, or other Federal or State cash assistance benefits?

□ No
□ Yes, provide onset date when benefit(s) commenced and monthly benefit amount.
□ I do not know. I am asking that this information be obtained. I understand there is an additional fee of $150.00 for this service and that the Request for Social Security Information authorization must be completed and returned.

a. Attach Social Security or State disability entitlement letter/ruling (initial letter received by Client advising entitlement to benefits or Administrative Law Judge ruling). Attach any other correspondence the Client has received from the Social Security Administration, or State Disability Determination Agency regarding eligibility or change in benefit status. *If entitlement letter/ruling is not available, please have the Client request a copy from the local Social Security District Office and forward at your earliest opportunity.*

2. If Client is *not* receiving Social Security disability, Supplemental Security Income, or other Federal or State cash assistance benefits now has an application for benefits ever been made?

□ No
□ Yes When and what is the status of the claim?

3. What is the Client's Average Current Earnings (ACE)? This figure can either be obtained from the initial entitlement letter from the Social Security Administration or can be requested from the local Social Security district office by use of the *Form for Requesting Social Security Information* attached. *Attach* a copy of the initial Social Security entitlement letter.

   □ ACE is: $
   □ I do not know and have requested this information be secured in QF1

G. Medicare/Medicaid Information:

1. Is or was the Client enrolled in Medicare, Medicaid or other Federal or State medical assistance programs?

   □ No
   □ Yes, if so, advise whether coverage Medicare Parts A, B, C, or D have been elected? What is the effective date of each coverage?

   Please attach a copy of your client's Medicare card or any State medical assistance card.

2. Has the Client submitted *any* medical bills to Medicare/Medicaid or to any other Federal or State agency for this injury(s)/illness *or other* medical condition?

   □ No
   □ Yes, please itemize. Note that Medicare/Medicaid and other Federal/ State agencies have rights of recovery for sums expended which will have to be repaid prior to distribution of the settlement proceeds.

   If you wish a Medicare Conditional Payment Search/Reconciliation please go to http://sevarino.lawoffice.com, download and return the MSPRC Request form with the requisite fee.

3. Have any lien letters been received by or on behalf of the Client indicating a claim against the settlement proceeds?

   □ No
   □ Yes, list and *attach* copies.

H. Concurrent Benefits:

1. Is there a third party concurrent personal injury case contemplated or pending?

   □ No
   □ Yes, complete details required. Is any repayment to the Workers' Compensation carrier or any other entity to be made from the settlement?

2. If the Client is receiving, or eligible to receive, public or private pension benefits or other short or long-term disability benefits?

   □ No
   □ Yes, complete details are required as these programs have their own offset or recovery provisions. *Attach copies of plans and paid benefit recap*.

I. Settlement:

1. What is the gross amount of the settlement? (If more than one entity will pay the proceeds indicate amount to be paid by *each* payor).

2. Is a structured settlement being utilized in the payment of the settlement proceeds?

   □ No
   □ Yes, *attach* copy of the structured settlement proposal

3. What is the attorney fee: $_____

4. What are the attorney's costs: $_____ (please itemize)

5. Repayment of liens?: $_____ (please itemize)

6. Other: $_____ (please itemize)

J. Additional Instructions/Comments:

Indicate any special instructions or special language required by the Respondent(s) or Defendant(s) which is to be included in the settlement documents. Indicate any special concerns you wish considered in the preparation of the settlement documents.

Authorization for Release of Protected Health Information

(In compliance with HIPAA Regulations - 45 C.F.R. 164.508)

Name:
SNN#:
Date of Birth:

I authorize the use or disclosure of my protected health information by your office, company or organization as specified below. I understand that signing this Authorization is voluntary and that my medical provider may not require me to sign this Authorization before my doctor, hospital or institution provides me with treatment. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to my medical provider. I understand that a description of my right to revoke my Authorization is set forth in my medical provider=s Notice of Privacy Practices. I understand that information is being released pursuant to this Authorization at my request and that the information may no longer be protected by law or regulation and may be redisclosed by the recipient.

1. a. Please use or disclose the following health information if such information exists:
   - G The entire medical record; or
   - G The following limited health information:

   b. Your medical institution/provider cannot use or disclose certain information unless you specifically authorize such use or disclosure. **Please initial next to each item below if you specifically authorize the release** of health information relating to the testing, diagnosis or treatment for:
   ___HIV/AIDS
   ___Drug and alcohol abuse
   ___Mental health/psychiatric disorders

5. Please specify the time period for the information you described above to be disclosed:

   - G All information maintained at any time by my medical provider or
   - G Information maintained by my medical provider from __/__/__to __/__/

6. Please specify who may receive the information requested by this authorization:

   Angelo Paul Sevarino, Esq., 26 Barber Hill Road, Broad Brook, CT 06016 (860-870-3803)

Unless earlier revoked, this authorization will expire one year from the date signed below, unless you specify an earlier date here: __/__/__.

By signing below, I understand and acknowledge the following:

- ! I have read and understand this Authorization;
- ! I am authorizing my medical provider to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization; and
- ! If I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact my medical provider=s Privacy Officer.
- ! A photostatic copy of this Authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Client Date

_____

Name if different then the Patient/Client

If signed by the Patient=s/Client=s personal representative, describe the legal authority of the representative to act on behalf of the Patient/Client._____.

Legal authority of representative verified by: _____-

Form for Requesting Social Security Information

TO: Social Security Administration

_____	_____	_____
Name	Date/Birth	Social Security No.

I authorize the Social Security Administration to release information or records about me to:

Angelo Paul Sevarino. Esq., 26 Barber Hill Road, Broad Brook, CT 06016

Reason I want this information released:

To establish my Social Security Disability status, date of entitlement to Medicare and the basis for Medicare entitlement (disability, age or ESRD) for the purpose of my workers' compensation claim. I understand there may be a charge for releasing information.

Please release the following information:

(A) Social Security entitlement status; (B) date of Social Security entitlement or date of application if still pending; (C) basis for entitlement (disability, age, ESRD); (D) Medicare status; (E)date of entitlement for Medicare A, B and/or D; (F) Supplemental Security Income entitlement; (G) Medicaid entitlement; (H) If not a current Social Security recipient, include number of eligible quarters/credits; (I) Initial PIA; (J) 80% ACE and (K) Family Max

I am the individual to whom the information/record applies, parent or the legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security, I could be punished by a fine or imprisonment or both.

Signature: _____Date: _____ Relationship: _____

FOR SSA USE ONLY

Is the individual *currently* a Medicare and/or Medicaid (SSI**)** recipient? Yes No

If yes, Is the individual receiving:

Medicare Part A	Yes No	Date of Entitlement: _____
Medicare Part B	Yes No	Date of Entitlement: _____
Medicare Part D	Yes No	Date of Entitlement: _____
SSI/Medicaid	Yes No	Date of Entitlement: _____

Is the individual insured for DIB? Yes No Number of Quarters/Credits: _____

Initial PIA_____ 80% ACE $_____ Family Max: $_____

If the individual is NOT receiving Medicare or Medicaid benefits please complete the following

Is the individual receiving *SS Retirement Benefits*? Yes No Effective Date: _____

Is the individual receiving DIB benefits but
Is not yet a Medicare beneficiary? Yes No Date of Entitlement: _____

Has a claim or request for hearing
For DIB/SSI benefits been filed? Yes No Date of Application: _____

SSA Representative Signature: _____