SOCIAL SECURITY OFFSET REQUEST & WORKSHEET

Note: This worksheet requests important information necessary in order to properly calculate what the potential Social Security offset, if any, would be to either workers= compensation or public disability benefits.

Incomplete or inaccurate information will delay calculation of the offset or may cause inaccurate assumptions to be formed and relied upon and may result in additional fees being charged.

This service does not include drafting of the settlement document but rather will provide appropriate language to insert in an existing settlement document. If a settlement document with client disclosure is being requested additional information regarding this service, as well as, fee=s associated with this service can be viewed visiting my website at http://sevarinolaw.com and scrolling down and clicking the AAttorney Services@ button and referring to AWorkers= Compensation Settlement Document Preparation@.

Note that where A**ATTACH**@ is reference the worksheet will reference when specific documents are being requested for return to my office.

Normal turn-around time is 10 business days from receipt of the completed request form with all necessary attachments included.

By signing below you agree and understand that:

1. You have obtained a signed HIPPA authorization from your client authorizing my office to review medical information relative to the preparation of the offset analysis and have forwarded said HIPPA authorization as part of this submission.

2. The fee for this service is $475.00 with the offset analysis and any proposed language sent via email in pdf format. A $35.00 additional fee will be charged if the documents are to be sent FedEx. While the exception, fees may be higher due to the failure to provide my office with the necessary and requested information or for revisions made to an original offset calculation as a result of additional material being forwarded which alters the opinion as to the offset. Before additional time is invested my office will contact you for authorization. Additional time will be billed at the hourly rate of $395 over the initial fee.

3. You and or your law firm are responsible for payment of all fees and this responsibility is not contingent upon any contractual relationship between you and your client or on ultimate approval of settlement.

4. All fees are due and payable 30 days from receipt of an invoice from my office and are not contingent upon receipt by you of settlement proceeds. Interest of 1.5% per month is charged for all outstanding invoices.

5. Unless checked below the offset analysis will be emailed to you, at the email address designated below, in pdf. format. If FedEx is requested below an additional $35.00 charge will be added to the invoice.

G I wish the offset analysis to be sent to the following email address:

_____

G I wish the offset analysis to be sent via FedEx

The signature of submitting attorney/party is required before the offset analysis may be prepared or released.

_____
Signature of submitting attorney/party

Date:

WORKSHEET

1. Name of Client:

2. Client=s Date of Birth:

3. Date(s) of Injury/Illness:

4. What is the Gross Settlement Amount: $_____

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

□ No

□BYes, **ATTACH** copy of the structured settlement proposal showing actual cost of the annuity, initial lump sum (seed) paid, number of periodic payments to be made, and periodic payment amount

5. Is any portion of the Gross Settlement Amount to be allocated specifically to the spouse and/or dependents?

□BNo

□BYes, amounts and to whom payable

a. Spouse=s name:

b. Date of Birth:

c. Date of Marriage to the Client:

d. 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):

6. 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*.

7. Indicate:

Client=s average weekly wage

$_____

Client=s base workers= compensation rate

$_____

Client=s *current* workers= compensation rate including COLAs

$_____

8. What is the total attorney fee plus costs charged to the client $_____

9. Has or will the client undergo a program of vocational rehabilitation?

□BNo

□BYes, 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?

10. Are there any accident related *unreimbursed* medical expenses still outstanding?

□BNo

□BYes, list and indicate amount and if they are *included in the gross settlement amount* or are to be paid by the Respondent-Employer or Respondent-Insurer *in addition to* the gross settlement amount.

11. Does the client=s require any retrofitting of the residence or other special equipment due to the work-related disability or impairment?

□BNo

□BYes, provide complete details and estimated costs.

12. Will the client have future work related medical services or prescription costs that would otherwise be covered and otherwise reimbursable by Medicare?

□BNo

□BYes, if a Medicare Set-aside has been completed please **ATTACH** copy.

□ Yes, a Medicare Set-aside has *not* been completed. I am providing my best projection of future work related medical services and prescription medications costs over the life of the client.

13. Will the client have future work-related medical services or prescription drug and non-prescription medication costs that would *not* otherwise be covered and otherwise reimbursable by Medicare?

□BNo

□ Yes, I am providing my best projection of future work-related medical services, prescription medication and non-prescription medication costs over the life of the client.

14. 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?

□BNo

□BYes, provide onset date when benefit(s) commenced and monthly benefit amount.

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.*

15. 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?

□BNo
□BYES, if so, when and what is the status of the claim?

16. What is the Client=s Average Current Earnings (ACE)?

□BACE is: $

□ I do not know. Have your client contact the local Social Security office and inquire. If you represented the client before the SSA you may make the inquiry.

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

□BNo
□BYes, list and **ATTACH** copies.

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:

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 C Yes No Date of Entitlement: _____
Plan name:_____
Medicare Part D Yes No Date of Entitlement: _____
Plan Name:_____

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: _____