# WORKERS= COMPENSATION SETTLEMENT VALUATION REQUEST & WORKSHEET

**Note:** This worksheet requests important information necessary in order to provide an opinion as to the settlement value range of the submitted workers= compensation case.

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

The normal charge for preparation of the case analysis is $1250.00. The fee does not include Medicare Set-aside calculations or preparations, Medicare Conditional Payment reconciliations, CMS referral or SSA request for information services. Additional information regarding these services, as well as, fee=s associated with these services can be viewed by visiting my web site at http://sevarinolaw.com and scrolling down to the button labeled AAttorney Services@.

While the exception, fees may be higher due to the failure to provide my office with the requested information or for revisions made to an original settlement valuation as a result of additional material being forwarded which alters the opinion. Before additional time is invested or billed my office will contact you for authorization. Additional time will be billed at the hourly rate of $395 over the initial fee.

Note that where A**ATTACH**@ is referenced in the worksheet 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 settlement valuation and have forwarded said HIPPA authorization as part of this submission.

**2.** The fee for this service is $1250.00 with the settlement valuation sent via email in pdf format. A $35.00 additional fee will be charged if the documents are to be sent FedEx. Once the settlement valuation has been released my office reserves the right to bill at the hourly rate of $395 for requested additional revisions. Additional fees will be discussed in advance of preparation of any revisions.

**3.** You are responsible for payment of all fees and this responsibility is not contingent upon any contractual relationship between you and your client or on approval of the 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 settlement valuation 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 case analysis to be sent to the following email address:

_____

G I wish the case analysis to be sent via FedEx

**The signature of submitting attorney/party is <u>required before</u> the case analysis may be prepared or released.**

_____

**Submitting Attorney/Party**

## 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).

**a.** Indicate any periods of concurrent employment that fall within the same 52 week period used to calculate the average weekly wage of the employer at which the injury occurred:

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

**D.** **Name(s) and Address(es) of all opposing counsel** (identify party represented or self-represented individual)

**E.** **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.

**F.** **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(s):

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

**5.** Accepted Body part(s)/system(s) involved (please be specific).

**6.** Denied Body part(s)/system(s) involved (please be specific. If any body part(s) or systems have been disclaimed or adjudicated as not compensable please **ATTACH** Form 43 or Finding & Dismissal.

**7.** For each injury or illness indicate any period(s) of (a) temporary total disability and (b) temporary partial disability

**8.** For each body part/system indicate (a) percentage of permanent partial impairment (b) indicate date of maximum medical improvement and (c) the physician=s name who established the rating

**9.** Indicate:

a. Client=s gross wages for the 52 week period preceding the date of injury (include any concurrent employment wages) $_____

b. Client=s established average weekly wage (include any concurrent employment wages) $_____

c. Client=s established base workers= compensation rate $_____

d. Client=s *current* workers= compensation rate including COLAs $_____

**10.** **a.** Select the Federal tax filing status of the Client based upon the Client=s actual filing status as of the date of injury:

G Single G Head of Household
G Married filing joint G Married filing separately

**b.** Number of exemptions including the Client as of the date of injury _____

**c**. Check all that apply to Client (as of the date of injury)

G 65 years of age or older G legally blind
G spouse 65 years of age or older G spouse legally blind

**11.** **ATTACH**:

**a.** all voluntary agreements
**b.** any proposed Stipulation
**c.** all Form 43/36s
**d.** all Commissioner Findings or Orders
**e.** indemnity and medical payment recap history from the workers= compensation carrier with a current run date
**f.** list of all prescription drug medications currently being taken including name of drug, name of doctor prescribing drug, reason the drug is being taken, whether the drug is being taken due to the work-related injury/illness, frequency and dosage of the drug

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

G No

G Yes. Is there any cost associated with this incurred or to be incurred by the Client? **ATTACH** any vocational analysis or functional capacity evaluations.

**13.** 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.

**14.** Does the claimant require any retrofitting of the residence or other special equipment due to accident related disability or impairment?

G No

GYes. Provide complete details and estimated vendor costs.

**15.** Will the Client require future medical services or prescription drug therapy expenses related to the workers= compensation injury or illness?

G No

GYes. If a Medicare Set-aside is *not* being requested please provide your medical services and prescription cost projections over the life of the claimant

## G. 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?

G No

G Yes. Provide onset date when benefit(s) commenced and monthly benefit amount.

G I do not know. You can ask your client to obtain this information from any local Social Security Office or you can utilize the attached A*Form For Requesting Social Security Information*@ to secure this information. If you wish my office to perform this service you understand there is an additional fee of $183.00 for this service and that the AForm For Requesting Social Security Information@ must be completed and returned along with the fee of $183.00.

**a.** **ATTACH** Social Security or State disability entitlement letter/ruling (initial letter received by claimant advising entitlement to benefits or Administrative Law Judge ruling). **ATTACH** any other correspondence the claimant 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?

G No

G Yes. Identify what benefit was applied for, when the claim was filed 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.

G ACE is: $

G I do not know and have requested this information be secured in question G1 above.

**H. Medicare/Medicaid Information:**

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

G No

GYes. If so, advise whether Medicare Parts A or B, Medicare Part C (Medicare Advantage Plan), or Medicare Part D (prescription drug coverage) have been elected? What is the effective date of each coverage? Note, clients may change plans so inquire as to all plans elected since the date of accident/illness.

| | |
|---|---|
| G Medicare Part A | Effective Date(s): |
| G Medicare Part B | Effective Date(s): |
| G Medicare Part C | Effective Date(s): |
| Name of Plan: | _____ |
| G Medicare Part D | Effective Date(s) |
| Name of Plan: | _____ |
| G Medicaid | Effective Date(s) |
| G Other Federal/State | Effective Date(s) |

(**ATTACH** a copy of your client=s Medicare card, Medicare Advantage Plan card Medicaid card or any State medical assistance card).

Note: If you wish my office to provide a Workers= Compensation Medicare Set-aside analysis please visit my web site http://sevarinolaw.com and scroll down and click the AAttorney Services@ button and then choose AWorkers= Compensation Medicare Set-aside (WCMSA) Services@.

**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?

G No

G 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.

Note: If you wish my office to provide a Medicare Conditional Payment Reconciliation visit my web site http://sevarinolaw.com and scroll down and click the AAttorney Services@ button and then choose AMedicare Conditional Payment Reconciliation@.

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

G No

G Yes. List and **ATTACH** copies.

## I. Concurrent Benefits:

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

G No

G Yes. Complete details required. Is any repayment to the Workers= Compensation carrier or any other entity to be made from the gross settlement proceeds?

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

G No

G Yes. Complete details are required as these programs have their own offset or recovery provisions. **ATTACH** copies of plans and paid benefit recap.

## J. Past Negotiations/Demands/Offers

Provide amount of any last demand, amount of last best offer by workers= compensation carrier or self-insured entity and an overview of any prior mediation or arbitration recommendation(s).

## Request for Social Security Information

TO: Social Security Administration

Name: Date of Birth: SSN:

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, possible offset implications, date of entitlement to Medicare and the basis for Medicare entitlement (disability, age or ESRD) for the purpose of my workers' compensation or personal injury 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) ACE and any offset notices or calculations 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:_____
Client/Plaintiff

**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 SSDIB? 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 SSDIB benefits but is not yet a Medicare beneficiary? Yes No
Date of Entitlement: _____

Has a claim or request for hearing for SSDIB/SSI benefits been filed? Yes No
Date of Request: _____

**SSA Representative Signature _____ Date:_____**

**Authorization for Release of Protected Health Information**
**(In compliance with HIPAA Regulations - 45 C.F.R. 164.508)**

To: RE: Name: Date of Birth: SSN:

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 re-disclosed by the recipient.

1. Please use or disclose the following health information if such information exists:

G The entire medical record; or
G The following limited health information:

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

2. 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 __/___/__

3. Please specify who may receive the information requested by this authorization: Angelo Paul Sevarino, Esq., 26 Barber Hill Road, Broad Brook, CT 06016 (860-716-0320)

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:

a. I have read and understand this Authorization;
b. 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
c. 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

Date:_____

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: _____