WORKERS' COMPENSATION CASE EVALUATION & SETTLEMENT VALUATION REQUEST WORKSHEET

Note: This worksheet requests important information necessary in order for me to provide an opinion as to settlement value range or case valuation 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 case analysis is $975.00.While the exception, fees may be higher due to failure to provide my office with the necessary and requested information or for revisions made to an original case analysis as a result of additional material being forwarded which alters my opinion as to case valuation. Additional time will be billed at the hourly rate of $395.00 over the initial fee.

Note that "**Attach**" will reference when specific documents are being requested to be attached to this completed worksheet and returned.

A. Claimant 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 Claimant:

8. Is the Claimant'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 Claimant (indicate if any child is not the issue of the marriage to the above named spouse and if so if the Claimant 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 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 and address of all opposing counsel** (identify party represented or pro-se parties).

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

5. Body part(s)/system(s) involved (please be specific) (indicate which are accepted and which are disclaimed)

6. 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 each body part/system, the rating for each body part/system, and the physician's name who established the rating.

7. What is:

a. Claimant's gross wages for the 52 week period preceding the date of injury $_____
b. Claimant's established average weekly wage $_____ .
c. Claimant's tax filing status as of the date of injury?
d. Claimant's established base workers' compensation rate $_____
e. Claimant's *current* workers' compensation rate including COLAs $_____

8. a. Select the Federal tax filing status based upon the Claimant's actual filing status as of the date of injury (must match Claimant's tax return, as if the Claimant was filing with the IRS on the date of injury)

❒ Single ❒ Head of Household ❒ Married filing jointly
❒ Married filing separately

b. Number of exemptions including the Claimant as of the date of injury? _____

c. Check all that apply (as of date of injury)

❒ Employee 65 years of age or older ❒ Employee legally blind

❒ Spouse 65 years of age or older ❒ Spouse legally blind

9. **Attach:**

a. all voluntary agreement(s)
b. any proposed draft Stipulation
c. all Form 43/36
d. all Commissioner Findings or Orders
e. indemnity and medical payment recap history from the workers' compensation carrier with 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

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

❒ No

❒ Yes Is there any cost associated with this incurred or to be incurred by the Claimant? If so, is this cost included in the settlement value? **Attach** *any vocational analysis or functional capacity evaluations*.

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 Claimant'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 Claimant have future medical services or prescription drug therapy expenses?

❒ No

❒ Yes. Please provide your medical cost projections over the life of the Claimant including medical services and prescription drug costs.

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

1. Is the Claimant now receiving, or has the Claimant 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(s).

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 Claimant request a copy and forward at your earliest opportunity.*

2. If Claimant 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 Claimant'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 am requesting Attorney Sevarino obtain this information pursuant to the signed authorization attached. I understand there is a fee of $150.00 to secure this information which fee is enclosed. Your claimant must sign and return the attached *"Request For Social Security Information"*

H. Medicare/Medicaid Information:

1. Is or was the Claimant 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?

Attach *a copy of your claimant's Medicare card, Medigap Supplemental Insurance Coverage or any State medical assistance card.*

If you wish a Workers' Compensation Medicare Set-aside analysis completed please download the *"Workers' Compensation Medicare Set-aside (WCMSA) Request"* from http://sevarinolaw.com. and return the completed form, required information and authorization with the requisite fee.

2. Has the Claimant 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 undertaken please download the *"Medicare Conditional Payment Request"* from http://sevarinolaw.com. and return the completed form, required information and authorization with the requisite fee.

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

❒ No

❒ Yes. List and **attach** copies.

I. 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 Claimant 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*.

J. Past Negotiations/Demands/Offers:

Provide last demand, last best offer for settlement and overview of any prior mediation sessions or mediators recommendation.

Request For Service:

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

All fees are due and payable 30 days from receipt of invoice 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 claimant that:

(a) no attorney-claimant relationship is being established between their claimant or principal and Angelo Paul Sevarino, Esq., and

(b) their claimant consents to Angelo Paul Sevarino, Esq. reviewing the submitted documents, including medical records and , if requested, communicating with the Social Security Administration as may be requested, and

(c) the Submitting attorney or party warrants to Angelo Paul Sevarino, Esq. the accuracy of all the information contained herein.

The signature of the Claimant and his or her authorized representative is <u>required before</u> the case review analysis may be prepared and/or released.

_____ _____

Claimant Signature (optional) **Submitting Attorney/Party Signature (required)**

Method of Receipt by your office of the Case Analysis:

❒ I request the case analysis be transmitted via email to:_____

❒ I request the case analysis be sent first class mail.

❒ I request the case analysis be sent via FedEx and understand an additional $35.00 charge will be added to the invoice.

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.

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 Barbara 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: _____

_____ **Date:_____**

Representative Signature

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