

PERSONAL INJURY SETTLEMENT PLANNING QUESTIONNAIRE

Booth Harrington & Johns of NC PLLC

The information requested in this questionnaire is for use by our law firm to devise a plan of asset preservation and/or Medicaid eligibility unique to your situation. We ask that you complete the questionnaire with as much detail as possible. The information that you disclose is confidential and is not shared with anyone outside this Firm, with the possible exception of the Department of Social Services when reporting receipt of settlement proceeds.

Date _____

By whom were you referred to this office? _____

1. PERSONAL INFORMATION

(The person for whom you are seeking legal advice)

Marital Status: Married _____ Single _____ Separated _____ Divorced _____ Widowed _____ Other _____

Individual receiving personal injury settlement

Full Name _____ Phone No. _____

Address (street/city/state/zip) _____

How long at this address? _____ Current Age: _____

Social Security Number _____ Date of Birth _____ US Citizen? Yes No

City, County, State of Birth _____

Are you a Veteran? Yes No Service Branch _____ Date of Death, if applicable _____

If yes, contact the Department of Veteran's Affairs at 1-800-827-1000.

Spouse (living or deceased) [If Applicable]

Full Name (include maiden) _____ Phone No. _____

Address (street/city/state/zip) _____

How long at this address? _____ Current Age: _____

Social Security Number _____ Date of Birth _____ US Citizen? Yes No

City, County, State of Birth _____

Are you a Veteran? Yes No Service Branch _____ Date of Death, if applicable _____

Reviewed by Intake Asst _____

Does Personal Injury Recipient have a Legal Guardian? Y / N If so, provide contact information:

Name _____
Address (street/city/state/zip) _____
Phone Numbers _____ Fax Number _____
Email Address _____
Relationship to Personal Injury Recipient _____
County of Guardianship _____ File Number _____

Other Contact Person (if not the individual, spouse, or Legal Guardian). If Contact Person has Power of Attorney for the Personal Injury Recipient, please include copy of that document. If more than one person is a contact person, please list additional people on back side of this page.

Name _____
Address (street/city/state/zip) _____
Phone Numbers _____ Fax Number _____
Email Address _____
Relationship to Personal Injury Recipient _____

2. HEALTH AND NURSING HOME INFORMATION

Name of Personal Injury Recipient _____
Diagnosis _____
Prognosis _____
Name and Contact Information for Institution where Personal Injury Recipient resides _____

Name of Living Spouse (If applicable) _____
Health Status of Spouse _____
Where Spouse Currently Resides _____

3. SETTLEMENT INFORMATION

Contact Information for Personal Injury Attorney

Name of Attorney _____

Name of Law Firm _____

Address (street/city/state/zip) _____

Phone Number _____ Fax Number _____

Email Address _____

Date of Injury _____

Nature of Personal Injury (e.g. slip and fall, car wreck, dog bite, medical malpractice)

Name of Tortfeasor / Defendant (and Insurer, if applicable) _____

Will a lawsuit be filed? Y / N

If so, what county? _____ File Number _____

Expected Settlement Amount

Gross Settlement \$ _____

Net Proceeds \$ _____

What is the fee arrangement with the PI Attorney? _____

Did Personal Injury Recipient receive either Medicaid or Medicare benefits at any time following the accident or injury?

Medicaid Y / N

Medicare Y / N

Do you anticipate that there will be liens or claims against the settlement by any of the following?

Medicare Y / N Anticipated Lien Amount \$ _____

Medicaid Y / N Anticipated Lien Amount \$ _____

Insurance Y / N Anticipated Lien Amount \$ _____

Other Y / N Anticipated Lien Amount \$ _____

Is your Personal Injury attorney investigating and handling those liens? Y / N

4. BENEFITS INFORMATION

Please indicate whether the PI recipient currently receives any of the following:

SSI <i>(Disability payment based on low income)</i>	Y / N	Monthly Payment \$ _____
RSDI <i>(Disability benefit based on work credits)</i>	Y / N	Monthly Benefit \$ _____
Medicaid	Y / N	Date approved _____ (month and year) County _____ Name of Caseworker _____ Medicaid ID Number _____
Special Assistance <i>(Assisted Living benefits)</i>	Y / N	Date approved _____ (month and year) County _____ Name of Caseworker _____
Medicare	Y / N	Date approved _____ (month and year) HIC # _____
Veterans Benefits	Y / N	Identification Number: _____ Benefit Type: _____ <i>(Pension, Aid & Attendance)</i>
Food Stamps	Y / N	Amount of Benefits \$ _____ County _____ Name of Caseworker _____
Section 8 Housing	Y / N	Name of Caseworker _____
TANF – NC Work First	Y / N	Name of Caseworker _____
Other Benefits		_____

Are any public benefits applications pending? Yes No

If yes, please indicate for what benefit program and the date of application _____

5. ASSETS

Please insert the approximate value of each asset/liability in the appropriate space. List Banks and Accounts numbers wherever possible:

ASSETS	ACCT TYPE ¹	INDIVIDUAL	SPOUSE	JOINT	LIABILITIES
BANKING ACCOUNT					
BANKING ACCOUNT					
BANKING ACCOUNT					
BANKING ACCOUNT					
HOME (ASSESSED TAX VAL)					
OTHER REAL ESTATE (TAX					
AUTOMOBILE(S)					
MUTUAL FUNDS					
STOCKS					
BONDS					
ANNUITIES					
*CASH VALUE - WHOLE LIFE					
IRA					
401K OR OTHER RET. PLANS					
NURSING HOME PATIENT ACCT					
PREPAID FUNERAL					
PREPAID BURIAL PLOT(S)					
OTHER					
TOTALS					

Use additional sheets, if necessary

*Detail on Page 6

¹ Type of Banking Account – CK-Checking; SV-Savings; MM-Money Market; CD-Certificate of Deposit - If any of your bank accounts are joint with children, please so indicate. If the bank account is "OR," please write "OR" next to account. If the account is "AND," please indicate by writing "AND."

6. LIFE INSURANCE

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

COMPANY (include Address and Policy Number)	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY

Medicare Supplemental Insurance	Company	Policy Number	Premium	Are these premiums paid from your retirement check?
For Individual	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
For Spouse	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicare Part D Insurance	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Long-Term Care Insurance	Company	Policy Number	Premium	Are these premiums paid from your retirement check?
For Individual	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
For Spouse	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

7. MISCELLANEOUS

Do you have any other legal issues of which we should be aware? If yes, please explain. Use separate sheet if necessary.

It is important that the above information be as accurate as possible. This information helps the attorney to give you the best possible information in your conference.

8. CERTIFICATION

The undersigned hereby each represents to Booth Harrington & Johns of NC PLLC, 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 that I am furnishing. 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 Clients or Client Representative:
