Attorney - Case Background

* Date of Completion ____
* Completed By ____

Items designated by a RED * are required fields

SECTION 1: Plaintiff Information - GENERAL

*Name		*Date of Birth	
*Address 1		Home Phone	
*Address 2		Mobile Phone	
*City		*Social Security #	
*State		Drivers License #	
Zip		*Medical Exp. to Date	$
		E-Mail Address	

Power of Attorney/OTHER *(if applicable)*

Power of Attorney	
POA Relationship	
Best POA Phone #	
Other Comments:	

SECTION 2: Plaintiff Attorney Information

Attorney Managing this Case

*Firm Name ____
*Name ____
*Phone ____
*Email ____

Paralegal Supporting this Case

*Name ____
*Phone ____
*Email ____

SECTION 3: Case Status/Attributes

*Date of Loss/Injury		*Is Case in Suit?	___ Yes ___ No	*Venue - County	
If yes, Index/Case No.		Title of Action		*Statute of Limitations?	___ years
*Is trial date set?	___ Yes ___ No	*If yes, enter date here		*Your best estimate of case close date	

SECTION 4: Establishing Defendant Liability

* Questions	* Defendant #1 *(required)*	Defendant #2 *(if applicable)*	Defendant #3 *(if applicable)*
Was there a Police Report/Accident Report? *(provide copy)*	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
If charged, did the Defendant plead guilty?	___ Yes ___ No ___ N/A	___ Yes ___ No ___ N/A	___ Yes ___ No ___ N/A
Has Defendant's insurance accepted liability?	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Did Defendant's insurance pay for property damage?	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
If yes, was amount reduced due to comparative fault?	___ Yes ___ No ___ % reduced	___ Yes ___ No ___ % reduced	___ Yes ___ No ___ % reduced

HMR Funding, LLC
9211 Arboretum Pkwy, Suite 500
Richmond VA 23236
Phone: 888-377-1245

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SECTION 5: Injuries/Causation/Past Medical

Type of Accident (motor vehicle, slip/fall, workers comp, other): ______

Was medical treatment received by plaintiff on date of incident? ___ Yes ___ No

* Area(s) of the body that is injured (be specific - ie left shoulder): ______

* Provide any insight into medical diagnosis/treatment thus far: ______

* What medical procedure(s) are required for this patient? ______

* Has any doctor indicated (by way of medical record or written narrative) that the injury that needs medical procedure is due to this incident (as opposed to a pre-existing condition). If yes, attach this document to this application. ___ Yes ___ No

Are there any concerns that the injury is an aggrevation of a pre-existing condition? ___ Yes ___ No If yes, comment here: ______

Has Plaintiff had past medical conditions on same body area? ___ Yes ___ No If yes, when (year) ___ If yes, what (detail) ______

Has Plaintiff had subsequent medical conditions on same body area? ___ Yes ___ No If yes, when (year) ___ If yes, what (detail) ______

Please provide any additional insight into the causation of the injuries: ______

SECTION 6: Insurance Review and Lien Verification

* Insurance/Coverage Information

Defendant's Carrier: ______

Driving a corporate vehicle? ______

Corporate Entity? ______

Coverage Amount: $ ______

Insurance Company: ______

Claim Number: ______

Denial of Coverage? ______

Plaintiff's Carrier: ______

Claim Number: ______

UM/UIM Limits: $ ______

Health Insurance? ___ Yes ___ No

Medicaid or Medicare? ___ Yes ___ No

Receive Social Security? ___ Yes ___ No

Has insurance co. issued a reservation of rights letter? ___ Yes ___ No

* Additional Information - Plaintiff

EXPLAIN ANY YES ANSWER

Been convicted of a Felony? ___ Yes ___ No ______

Been a defendant in a case? ___ Yes ___ No ______

Declared Bankruptcy? ___ Yes ___ No ______

Changed attorneys in this case? ___ Yes ___ No ______

Obtained a Prior Advance ___ Yes ___ No ______

Filed lawsuit for injury for same area of body? ___ Yes ___ No ______

* Liens

* Are there any liens on the case at this time? ___ Yes ___ No

* If yes, what is the total $ Value of ALL Liens $ ______

What is your % fee on the case (ie 33%, 40%, etc.)

What are your expenses to date on this case? $ ______

How much have you paid for medical treatment for the P? $ ______

Living Expense liens to date $______

* Lien Details

Are there any Hospital or Provider liens? ___ Yes ___ No If Yes $ ___ K

Are there any PIP liens? ___ Yes ___ No If Yes $ ___ K

Are there any workers comp liens? ___ Yes ___ No If Yes $ ___ K

Are there any Medicare/Medicaid liens? ___ Yes ___ No If Yes $ ___ K

Is there an ERISA lien? ___ Yes ___ No If Yes $ ___ K

Is there a Private Insurer involved? ___ Yes ___ No If Yes $ ___ K

Any Others? If yes, who? ______ ___ Yes ___ No If Yes $ ___ K

Comments here (if any): ______

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* SECTION 7: CHECK LIST - IMPORTANT *(be sure to provide each line item that is available)*

Description	Yes	No	N/A
Police Report/Accident Report			
Declaration Page from Defendant Insurance Policy			
Declaration Page from Plaintiff Insurance Policy			
Expert Witness Reports/Letters *(if available)*			
Witness Statements *(if available)*			
Photos of Property Damage *(if available)*			
All Medical Records *(if available)*			
Medical Bills to Date *(if available)*			

*SECTION 8: DESCRIPTION OF CASE *(write and attach - be thorough)*

EXAMPLE ONLY ATTACH YOUR CASE SUMMARY TO THIS AP

My client is a 42 year old male - DOB 7/4/70 - no health insurance
DOL 4/15/11- Motor vehicle accident - Have witness statements
75% admitted liability from defendant
$300K defendant insurance per DEF policy declaration page
Meds to date $22,000, no Medicaid or other liens (med bills attached)
Injuries include spine/back - have positive MRI indicating disc protrusion
Two rounds of soft tissue injections have failed - surgury likely
Dr. Tom Smith at (123) 456-7890 is provider
Need advance for surgery and rehab - client cannot wait and cannot work
Trial date is expected spring of next year (no date at this time)

ACKNOWLEDGEMENT - RELEASE OF MEDICAL RECORDS

In connection with this case, certain medical records ("Medical Records") related to Patient will be created, including without limitation, images, physician notes, lab reports, invoices and bills. The Medical Records constitute the Protected Health Information (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder) of Patient. The Patient has authorized this firm to release the Medical Records to HMR Funding, LLC and its affiliates and those providers HMR Funding, LLC or its affliliates may be contracting with, or considering to contract with, as the payor of medical services on behalf of the patient. The authority of Patient's attorney under this Release will terminate upon termination of such attorney's representation of Patient. The authority under this Release will terminate upon Medical Provider's receipt of payment in full for all amounts owed to Medical Provider in connection with the Services. Patient may, in its sole discretion, revoke this Release at any time, by providing written notice to this firm.

LETTER AGREEMENT RELATED TO ASSIGNMENT AGREEMENT

This Letter Agreement is delivered by the attorney of the Patient (as defined above) to HMR Funding, LLC and its Affiliates ("Assignee") in connection with separate Assignment Agreement(s) (each, an "Assignment") by and between Patient and certain medical providers (each a "Medical Provider") that provide medical services to Patient in connection with the incident ("Incident") that occurred on the Incident Date identified above. As the Patient's attorney, we acknowledge that Patient has or will irrevocably assign the Proceeds (as such term is defined below and up to the amount ("Expense Amount") indicated on the corresponding billing statement(s) provided by the applicable Medical provider) to the applicable Medical Provider, and that such Medical Provider then assigned the Proceeds up to the Expense Amount to Assignee, and we agree, to the best of our ability, to honor such assignments, including without limitation by causing the full Expense Amount to be paid to Assignee if and promptly after we receive corresponding Proceeds. The term "Proceeds" means proceeds recovered on Patient's behalf that arise out of any litigation, judgment, verdict, settlement, arbitration or mediation, or any other collection activities related to Patient's pending or subsequent claim(s) and/or action(s) related to the Incident. In the event we recover Proceeds on behalf of Patient, we agree to (a) withhold from such Proceeds, after deduction of attorneys' fees and costs, all amounts necessary to pay the Expense Amounts, as such amount is communicated by the applicable Medical Provider to us and/or Patient; and (b) promptly remit to Assignee (at the address set forth above), the portion of such Proceeds necessary to cover the Expense Amounts. To the extent the Proceeds that are recovered are not sufficient to allow our firm to pay the Expense Amount in full to Assignee, we agree to reduce out attorney's fees related to the Incident proportionately with the reduction in the Expense Amount to be paid to Assignee. For the avoidance of doubt, it is the intention of the immediately preceding sentence that any reductions should be shared equally by my firm and Assignee. In no event does this Letter Agreement make me, or my firm, responsible or liable for the Expense Amounts. We will use our best efforts to notify the applicable Medical Provider and Assignee upon (a) the anticipated and/or actual receipt of Proceeds; (b) any termination, if any, of our legal representation of Patient; or (c) any change in our contact information.

Summary

To the best of my knowledge, the information contained in this application is true and is an accurate summary of this case.

By my signature below, I/We hereby certify that this signature is on behalf of the Firm and Attorney in Charge.

Attorney Signature: ____________________

Attorney Name: ____________________

Title: ____________________

Date: ____________________

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