Case Qualification Form

P&T
Financial

Date Referred: _____/_____/_____

Consultant Name: _____

Consultant Phone: (_____) _____ - _____ Fax (_____) _____ - _____

CLIENT INFORMATION:

Plaintiff Name: _____ Date of Birth: _____

Date of Accident: _____ Social Security: _____

Address: _____ State, State, Zip: _____

Cell Phone: _____ Home Phone: _____

Amount Needed: $_____ Date Needed: ___/___/___ Reason: _____

Other Accidents: Y / N Prior Injuries Y / N Subsequent Injuries Y / N Child Support: Y / N

Loss of Work: Y / N Criminal Record: Y / N Alcohol or Drug Use: Y / N

Other Advances: Y / N Advance Amount: _____ Date Advance Taken: _____

ATTORNEY INFORMATION:

Law Firm: _____ Lawyer: _____

Address: _____ City, State, Zip: _____

Phone: _____

Fax: _____

INCIDENT INFORMATION:

Case Type: ___ Auto ___Med Mal ___ Workers Comp ___ Premises Liability ___ Assault ___ Other _____

Case Details: _____ Extent of Injuries: _____

# of people in vehicle: _____ Driver or Passenger? _____ Surgery? Y / N

Approx. Medical Costs to Date $_____ Are Medical Bills Paid? Y / N Medical Bills Paid By: ____ PIP ____ Liens on Case ____ Other

Approx. Property Damage __$250-1000 __$2000-5000 __$6000–10,000 __Other _____

Approx. Lost Wages: __$250-1000 __$2000-5000 __$6000–10,000 __Other _____

Approx. Workers Comp Liens __$250-1000 __$2000-5000 __$6000 – 10,000 __Other _____

Approx. Legal Expenses: __$250-1000 __$2000-5000 __$6000 – 10,000 __Other _____

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