

P & T
Financial

Case Qualification Form:

Date Referred: _____

Form Completed by: _____

___ Pre-Settlement Advance ___ Attorney Disbursement Funding

Fax to (650) 591-6120

CLIENT INFORMATION:

Date of Accident: _____ Date of Birth: _____

Plaintiff Name: _____ 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 Loss of Work: Y / N

Child Support: 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: **Law Office of** _____ Lawyer Assigned: _____

Address: **Address** _____ Paralegal Assigned: _____

Phone: **Number** _____

Fax: **Number** _____

INCIDENT INFORMATION:

Case Type: _____ ___ MVA ___ Med Mal ___ Workers Comp ___ Premises Liability ___ Assault ___ Other

Accident Details: _____ Injury Details: _____

Theory of Liability: _____

Est. Settlement Date: _____ Est. Settlement Range: _____

Est. Trial Date: _____ Est. Verdict Range: _____

Settlement Offer: Y / N Settlement Amount: \$ _____ Demand Letter: Y / N Demand Amount: \$ _____

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Approx. Medical Bills 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 _____

SOURCES OF RECOVERY:

Defendant(s)	Insurance Company	Coverage	Claim #
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____

Plaintiff(s) / 1 st Party	Insurance Company		
1) _____	_____	<input type="checkbox"/> Full Tort	Coverage: \$ _____
		<input type="checkbox"/> Limited Tort	_____
		<input type="checkbox"/> Underinsured	Claim # : _____
		<input type="checkbox"/> Uninsured	_____
2) _____	_____	<input type="checkbox"/> Full Tort	Coverage: \$ _____
		<input type="checkbox"/> Limited Tort	_____
		<input type="checkbox"/> Underinsured	Claim # : _____
		<input type="checkbox"/> Uninsured	_____

DOCUMENTS FOR SUBMISSION:

If yes, please submit for review. These documents will be used to evaluate your plaintiff's case.

ER Visit: Y / N Date: _____
 1st Doctors Visit: Y / N Date: _____
 Police Report Y / N City, State, County: _____
 Operation: Y / N Surgery Summary: _____

"X" All Docs Included:

<input type="checkbox"/> ER Report	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> MRI /X-Ray Report	<input type="checkbox"/> Expert Report
<input type="checkbox"/> Police Report	<input type="checkbox"/> Accident Report	<input type="checkbox"/> Complaint	<input type="checkbox"/> Determination of Complaint
<input type="checkbox"/> EEOC			

Thank you for this valuable information. We will contact you and/or your client in regards to this submission within 2 business days.