

TRIAL LAWYERS CARE

80 Centre Street, Suite 290, New York, NY 10013

917-464-0105 (voice) • 917-464-0160 (fax) • tlc@911lawhelp.org (e-mail)

CLAIMANT QUESTIONNAIRE

Trial Lawyers Care (TLC) was formed to provide experienced lawyers, free of charge, to victims of the September 11th terrorist attacks and their families. A TLC lawyer will be made available to 1) provide information about the federal Victim Compensation Fund, 2) help you decide whether or not to bring a claim under the Fund, and 3) represent you if you file a claim.

To request free legal assistance, please answer the questions listed below as best you can. You may fax the completed questionnaire to us at 917-464-0160 or mail it to us at the address above.

1. CLAIMANT INFORMATION:

Name: _____
(Last) (Middle) (First)

Street Address: _____

City: _____ State: _____ Zip: _____

Country (if other than USA): _____

Work Phone: _____ Home/Cell Phone: _____

Fax: _____ Email: _____

Claimant's Date of Birth: _____, 19_____

2. HAVE YOU FILED A CLAIM WITH THE VICTIM COMPENSATION FUND?

Yes No Not Necessary Other

Victim Compensation Fund Claim Number _____

If your response is anything but *yes*, please explain briefly: _____

Are you requesting assistance with an appeal only? Yes No

If *yes*, is this an appeal from an award? Yes No From a denial of eligibility? Yes No

3. WHERE DID THE PHYSICAL INJURY OR DEATH OCCUR?

World Trade Center Pentagon Shanksville, PA

4. VICTIM INFORMATION:

(A Victim is either someone who died in the September 11 attacks [known as a *Decedent*] or someone who survived the attacks, but received physical injury [known as a *Survivor*].

The victim is a *Decedent* - OR - a physically injured *Survivor* (please continue with Paragraph 8 at page 3)

5. IF THE VICTIM IS A DECEDENT:

Claimant's relationship to the decedent: (check one):

Family (specify relationship) _____ Other (explain) _____

Decedent's Name: _____
(Last) (Middle) (First)

Decedent's Date of Birth: _____, 19____

6. INFORMATION ABOUT THE PERSONAL REPRESENTATIVE OF THE DECEDENT'S ESTATE:

The Personal Representative (administrator or executor of the Decedent's estate) is appointed by the court or by will.

I am the personal representative of the Decedent's estate

I do not know the name of the Personal Representative

If you are not the personal representative of the Decedent, but know the Personal Representative's name, please fill in this section:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____ Country (if not USA): _____

Work Phone: _____ Home Phone: _____

Fax: _____ Email: _____

7. DECEDENT'S CHILDREN AND/OR OTHER DEPENDENTS:

Please list all of the decedent's children now living, including adopted children, any children of a former marriage or born out of wedlock. Indicate 1) the other parent if it is not you, 2) the children's ages, and 3) if the child was dependent upon the decedent for support (attach an additional sheet if necessary):

	<u>Name</u>	<u>Age</u>	<u>Other Parent (if applicable)</u>	<u>Dependent?</u>
Child 1	_____	_____	_____	<input type="checkbox"/>
Child 2	_____	_____	_____	<input type="checkbox"/>
Child 3	_____	_____	_____	<input type="checkbox"/>
Child 4	_____	_____	_____	<input type="checkbox"/>

<u>Adult Dependents:</u>	<u>Name</u>	<u>Age</u>	<u>Relationship to Decedent</u>	<u>Dependent?</u>
Adult Dependent 1	_____	_____	_____	<input type="checkbox"/>
Adult Dependent 2	_____	_____	_____	<input type="checkbox"/>

Please continue with Paragraph 10 on page 4

8. IF THE VICTIM IS A PHYSICALLY INJURED SURVIVOR:

Were you a rescue or recovery worker? Yes No Not sure

If you aren't sure, please describe briefly what you were doing at the crash site:

If you *were not* a rescue or recovery worker, did you seek medical attention within 72 hours of the attacks?

Yes No

If you *were* a rescue or recovery worker, were you present at one of the crash sites at any time within the first 96 hours after the attacks? Yes No

9. PLEASE DESCRIBE BRIEFLY THE NATURE AND EXTENT OF YOUR *PHYSICAL* INJURIES:

Are any of your physical injuries, incapacity or disfigurement permanent? Yes No Don't know

If you answered *yes*, are you 100% disabled by your physical injuries?

partially disabled (___ percent, if you know) by your physical injuries?
Don't know

If you answered *no*, were you temporarily partially or totally disabled, incapacitated or disfigured as a result of your physical injuries? Yes No

Did you spend at least 24 hours in the hospital as an inpatient?

Yes No

If you answered *yes*, when? _____

If you were a rescue/recovery worker who did not seek medical attention immediately, has your physician linked your injuries/illness to the time you spent at one of the crash sites during the first 96 hours after the attacks?

Yes No

10. EMPLOYMENT/BUSINESS/OTHER INCOME LOSS

A. Where was the Victim employed on September 11, 2001?

Name of Employer: _____

Address of Employer _____

Mo./Yr. Employment Began _____

B. If the Victim was employed elsewhere in 1999 and 2000 and/or was employed at more than one business, please indicate the names and addresses of the Victim's other employers below.

C. Please indicate the Victim's gross annual income (if known) for:

1998: _____

1999: _____

2000: _____

2001: _____

If the Victim was injured, 2002: _____ 2003: _____

D. Did the Victim own or operate a business at the time of the September 11 attacks?

Yes No

If yes: Name of Business: _____

Address: _____

City, State, Zip: _____

Nature of Business: _____

11. LANGUAGE REQUESTS:

If you do not speak English, what language do you speak? _____

Do you know someone who can translate for you and your attorney? Yes No

If you have answered yes, please fill in the person's contact information in Paragraph 12 below.

12. DO YOU HAVE A CASE WORKER, FAMILY MEMBER OR OTHER FRIEND OR ADVOCATE WHOM WE MAY CONTACT IF YOU ARE NOT AVAILABLE?

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (work) _____ (other) _____ email: _____

13. PLEASE INDICATE YOUR PREFERENCE FOR AN ATTORNEY:

TLC will make every attempt to accommodate this preference, but we are very short of attorneys in the New York/New Jersey area. If we cannot find an attorney in your area, we have many out-of-state attorneys willing to travel to you as many times as necessary at their own expense.

City: _____ State: _____

If there are no TLC attorneys available in your area, will you accept an attorney who will travel to your area at his or her own expense: Yes No

Please note that if you answer *no*, we cannot guarantee that we will be able to refer you to an attorney.

14. HAVE YOU HIRED ANOTHER LAWYER TO REPRESENT YOU BEFORE THE VICTIM COMPENSATION FUND?

Yes No

If *yes*, please provide the following information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Email: _____

15. ARE THERE ANY OTHER EXTRAORDINARY FACTS OR CIRCUMSTANCES THAT YOU WISH TO SHARE THAT MAY AFFECT YOUR POTENTIAL CLAIM?

NOTHING CONTAINED IN THIS DOCUMENT SHALL BE VIEWED AS GIVING LEGAL ADVICE. LEGAL ADVICE CAN AND SHOULD ONLY COME FROM THE LAWYER TO WHOM YOU ARE REFERRED BY TRIAL LAWYERS CARE OR WHOM YOU HIRE.