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An Outline of Required Information for Estimating the Economic Value of the Diminution of an Individual's Earning Capacity, the Cost of Attendant and/or Medical Care and the Loss of Household Services

I. Background and Case Information

A. Name of injured: ____

B. Race: White ____ Black ____ Other ____________

C. Sex/Gender: ___________________

D. Date of birth: ___________________

E. Date of incident or injury (and initial date of earnings loss or impairment, if different from date of incident): __________________________

F. Type of Incident/Accident and Injury: ___________________________________

G. Trial/Mediation date(s): _____________________

H. Copy of Complaint. Please indicate if this analysis is to be calculated under:
   1. Florida Medical Malpractice Arbitration Statute § 766.207 **Yes** ____ **No** ____
      If so, Date of Arbitration ___________________

   2. Federal Court (i.e. Rule 26) **Yes** ____ **No** ____

II. Estimating the Loss or Diminution of an Individual's Earning Capacity

H. Previous occupational and earnings history (i.e. preferably copies of the income tax returns **with** W-2 forms for the five years prior to the incident).

I. Verification of his/her rate of pay (i.e. copies of pay stubs; payroll records; personnel records).

J. Verification of the plaintiff's employer's contributions to fringe benefits (i.e. health, dental and life insurance, 401K savings plan, etc.) as well as the plaintiff's current contributions/costs for those same benefits (see Attachment A).

K. Educational Attainment (and, in case of child, a verification of class standing via school records preferably). This is mandatory in a case where injured has had no work record or work history is spotty.

L. Date of return to employment and/or date of maximum medical improvement, as well as, income tax returns for the years subsequent to the incident. ______________________________

M. Has a vocational/rehabilitation specialist been retained to determine the plaintiff's pre- vs. post- incident earning abilities? In addition, a vocational rehabilitation expert may also be helpful in establishing the pre- and post-incident earning potential for a child.

N. Any information relative to the impact of the incident on the plaintiff's work-life expectancy (i.e. has incident decreased the probability that the plaintiff will have a normal work-life expectancy).

III. Cost of Attendant and/or Medical Care

O. Has a rehabilitation expert been retained to outline the cost of the future medical care that the plaintiff may require?

P. If the cost of the plaintiff's future medical care needs are not provided in the form of a life care plan or rehabilitation plan, we will need the cost, frequency and duration* of each medical care item that is required. (*If the duration is different from the plaintiff's life expectancy). It is especially important to consider the impact that the injury might have on the plaintiff's life expectancy.

IV. Loss of Household Services (see Attachment B)

If a claim is being made for the loss of the plaintiff's services in and around the household, a statement will be required (from the plaintiff's spouse and/or children), defining and delineating the nature and extent (number of hours per week) of services which the injured party had been providing (see attached).

ATTACHMENT A

VALUE OF EMPLOYER FRINGE BENEFIT CONTRIBUTIONS

This form provides information which will be used to determine the value of employer contributions to fringe benefit plans. Please provide the following information from the plaintiff's most recent employer and return completed form.

Plaintiff (Employee): ____

Company: ____

Position Held: ______________ Employment Dates: ____________________

Base Gross Annual Salary = $____________________

Please obtain the following information from employer and attach supporting documentation confirming these values:

	Company Share Only			**Employee Share**	
	Dollars Per (month, year, etc please specify)	**OR**	As percent of Gross Annual Salary	Pre-Incident	Post-Incident
1. Retirement and Savings Contributions:					
a. Defined Benefit Pension Plan	$__________		__________%	$__________	$__________
b. 401K Plan	$__________		__________%	$__________	$__________
c. **Profit Sharing**	$__________		__________%	$__________	$__________
d. ESOP	$__________		__________%	$__________	$__________
e. Other Retirement Plan	$__________		__________%	$__________	$__________
2. Medical & Medically Related Benefits:					
a. Hospital, Surgical, Medical	$__________		__________%	$__________	$__________
b. Dental	$__________		__________%	$__________	$__________
c. Vision	$__________		__________%	$__________	$__________
d. **Other (Please Specify)**	$__________		__________%	$__________	$__________
3. Miscellaneous Benefit Programs:	$__________		__________%	$__________	$__________

ATTACHMENT B

LOSS OF HOUSEHOLD SERVICES INFORMATION

Plaintiff: ______________________________ **Attorney:** ______________________

This form provides information which will be used to determine the extent (in hours per week) of the loss of household services sustained by the injured party. Please indicate the amount of time spent on each activity on a per week basis (including weekends).

NOTE: THERE IS A TOTAL OF 168 HOURS IN ONE WEEK. PLEASE DO NOT INCLUDE TIME FOR OUTSIDE EMPLOYMENT, PERSONAL HYGIENE, RECREATION OR SLEEPING.

	Pre-Incident Hours/Week*	Post-Incident Hours/Week
1. **ROUTINE/DAILY ACTIVITIES:** (including vacuuming, dusting, laundry, ironing, shopping for household supplies, etc.)	________	________
2. **COOKING:** (including shopping, preparation, clean-up, etc.)	________	________
3. **REPAIR AND MAINTENANCE:** (including carpentry, electrical, pool, plumbing, painting, renovation/refurbishing, auto, boat, etc.)	________	________
4. **YARD WORK:** (including mowing, trimming, raking, watering, etc.)	________	________
5. **HOUSEHOLD MANAGEMENT:** (including bookkeeping, bill paying, tax preparation, etc.)	________	________
TOTAL HOUSEHOLD SERVICES PER WEEK:	________	________

CHILDCARE SERVICES (independent of household services):

Direct childcare services (including supervising household children *independent of other household tasks* (estimated above), bathing, feeding assisting with homework, chauffeuring, etc.); in addition we will need children's dates of birth.

TOTAL CHILDCARE SERVICES PER WEEK	________	________

***If the time indicated is anything other than on a "per week basis" please specify (i.e. daily, monthly, annually).**

Information provided by (Name):______________________ **Date:** ______________