



## **Delta Economics Questionnaire**

**CASE NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Client(s):** Plaintiff: \_\_\_\_\_ Defendant: \_\_\_\_\_

**Attorney(s):** Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

**Legal Assistant(s):** Name: \_\_\_\_\_ Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

**Court Information:** Location: \_\_\_\_\_ Case No.: \_\_\_\_\_

Court: \_\_\_\_\_ Trial Date: \_\_\_\_\_

Judge: \_\_\_\_\_

### **Checklist of Information For Determination of Economic Loss**

**1. Computation needed for:**

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

**2. This case involves:** \_\_\_\_\_ Death  
 \_\_\_\_\_ Personal Injury  
 \_\_\_\_\_ Job Loss or Discrimination  
 \_\_\_\_\_ Other (Explain) \_\_\_\_\_

**3. Date of accident, termination, etc.:** \_\_\_\_\_

**4. Family:**

Name	Birth Date	Relationship	Sex	Education
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Fact Finding Questionnaire | CONFIDENTIAL

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**5. Vocational Evaluation:** In disability or employment termination matters a vocational evaluation is recommended to establish the foundation for the economic analysis.

Vocational specialist is being retained    ☐ Yes                      ☐ No

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
                   \_\_\_\_\_  
                   \_\_\_\_\_

**Please attach a copy of resume and evaluation.**

**6. Education/Training:**

School	Location	Years	Diploma
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**7. Employment Record:** (Please indicate date last worked if relevant.)

Employer	Dates	Job	Pay Rate
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**8. Earning Record:** Please attach clear copies of Income Tax and W-2 Forms for as many years as possible before the event in question, and since, if any. Indicate any disability/death benefits received.

**9. Career goals, plans or other information:**

**10. Employer Paid Fringe Benefits:** (Check those received and give dollar amounts if possible.)

	Before		After	
	Received?	Employer Cost	Received?	Employer Cost
	Yes or No	\$	Yes or No	\$
Social Security	_____	_____	_____	_____
Pension Plan	_____	_____	_____	_____
401(k) Plan	_____	_____	_____	_____
Workers' Compensation	_____	_____	_____	_____
Life Insurance	_____	_____	_____	_____
Health Insurance	_____	_____	_____	_____
Dental Insurance	_____	_____	_____	_____
Major Medical/Disability	_____	_____	_____	_____
Unemployment Insurance	_____	_____	_____	_____
Meals and Other Expenses	_____	_____	_____	_____
Savings and Thrift Plans	_____	_____	_____	_____
Travel	_____	_____	_____	_____
Company Car	_____	_____	_____	_____
Other	_____	_____	_____	_____

Employee manuals, benefit handbooks, etc., can also be useful.

**11. Union Member?**      Union Name: \_\_\_\_\_  
       \_\_\_Yes                Local Number: \_\_\_\_\_  
       \_\_\_No                Local Address: \_\_\_\_\_  
                                  \_\_\_\_\_  
                                  \_\_\_\_\_

Please attach copies of past and current union contracts if available.

**12. Other Wage, Benefit or Employment Information:**

In wrongful death cases, please be sure that the spouse's earned income record is also provided by W-2's if possible.

**13. Household Work Activities** (Please indicate average hours per week if there is a loss of household services.)

	Before	After	Replacement*
Automotive	_____	_____	_____
Child Care	_____	_____	_____
Cleaning	_____	_____	_____
Cooking	_____	_____	_____
Electrical	_____	_____	_____
Finances	_____	_____	_____
Laundry	_____	_____	_____
Maintenance & Repairs	_____	_____	_____
Painting	_____	_____	_____
Plumbing	_____	_____	_____
Shopping	_____	_____	_____
Yard/Garden	_____	_____	_____
Other (list)	_____	_____	_____
<b>Total Hours Per Week</b>	_____	_____	_____

\*Indicate where relevant how these are being replaced or if they are being left undone.

**14. Medical—Rehabilitation—Training Expenses To Date:**

	Frequency	Duration*	Unit Cost	Source of Information
Hospitalization	_____	_____	_____	_____
Doctors' Care	_____	_____	_____	_____
Nursing Care	_____	_____	_____	_____
Medicines	_____	_____	_____	_____
Appliances	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
Vocational Therapy	_____	_____	_____	_____
Psychological Therapy	_____	_____	_____	_____
Transportation	_____	_____	_____	_____
Other (list)	_____	_____	_____	_____
	_____	_____	_____	_____

**15. Expected Future Medical—Rehabilitation—Training Expenses or Life Care Plan:**

	Frequency	Duration*	Unit Cost	Source of Information
Hospitalization	_____	_____	_____	_____
Doctors' Care	_____	_____	_____	_____
Nursing Care	_____	_____	_____	_____
Medicines	_____	_____	_____	_____
Appliances	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
Vocational Therapy	_____	_____	_____	_____
Psychological Therapy	_____	_____	_____	_____
Transportation	_____	_____	_____	_____
Other (list)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

\*Life, 5 years, 1 year, etc.

**16. Additional biographical, medical, or other information which may be of importance:**

**17. Form Completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_