INSTRUCTIONS

DHS 1125A (Rev. 10/04)

SUPPLEMENT TO ASSIGNMENT OF PAYMENT - DHS 1125

PURPOSE:
This specific information is necessary for the Department to appropriately identify case situations where recovery of medical payments made in behalf of recipients can be initiated.

SPECIFIC INSTRUCTIONS:
Complete a separate Form 1125A for each family member injured in an accident. It is imperative that each section be completed as fully as possible for the recovery of medical payments.

1.	**Name of Injured:**	Indicate last name, first, and M.I. of injured recipient
	Address:	Self-explanatory.
	Case Name:	Indicate name of case in HAWI
2.	**ID No.:**	Recipient's HAWI I.D. number
	Case No.:	Case number in HAWI
	SSN:	Recipient's social security number
	Date of Birth:	Recipient's date of birth
	Sex:	Recipient's sex
3.	**Date of Accident:**	Indicate date when was the accident occurred (MM/DD/YY)
4.	**Application Date:**	Indicate date applied for assistance (MM/DD/YY)
	Medical Eligibility Date:	Indicate effective date of medical coverage (MM/DD/YY)
5.	**Type of accident:**	Indicate with an "**x**" mark the type of accident (e.g. workers compensation, assault, etc.)
6.	**Medical Coverage:**	Indicate with an "**x**" mark if client has regular Medicaid or QUEST Health Plan coverage. If QUEST, write name of QUEST Health Plan. For **Other(s) Hosp. & Med Ins.**, indicate all other health or medical insurance carriers such as HMSA private plan, Kaiser private plan, Medicare, etc.
7.	**Provide a clear description of how the accident occurred:**	Explain how the accident happened. Provide clear description of accident including actual time and location where accident occurred. (Information is needed to establish liability). For example: "Hit by a car from the rear - three car accident," "Hit by car while crossing the street - was in crosswalk," "Injured as a passenger - the other car ran the red light and hit my driver's car," "Injured as a driver in a one car accident - hit a telephone pole," "Injured in a store - portable broom rack fell on me," or "Injured on the job while lifting heavy equipment", etc.
8.	**Describe the type of injury:**	Indicate what part(s) of the recipient's body was injured. (For additional space, use Section 19 Other Information).

		For example: "Fracture of the right or left arm, broken ribs, spinal injury, pelvis area", etc. (e.g. broken arm, head injury facial cuts, fractured leg, etc.)
9.	**Extent of Injury:**	Indicate the extent of recipient's injuries (serious, slight, etc.)
10.	**Recipient treated/seen by:**	List names of doctors, hospitals, laboratories, etc. (Provide names of doctors, hospitals, laboratories, radiologists, pharmacists, dentists, etc.).
11.	**Is recipient still under medical care for his/her injury?:**	Indicate with an "**x**" mark after "YES" or "NO".
12.	**Person(s)/property owner other than recipient who may be at fault:**	List <u>all</u> names of persons (other than recipient) who <u>may be</u> at fault and their insurance companies.
	Their Insurance Co., and Policy No.:	List insurance companies and policy number.
	Example:	
	a. <u>Auto Accident</u>	Their insurance companies and policy number, Name of the driver of the vehicle and insurance company and policy. Indicate driver with "D" after the name. If vehicle is owned by someone else, give the name of the vehicle owner and insurance company and policy number. For three-car collision or more, repeat the same.
	b. <u>Personal Injury</u>	Name(s) of the person(s) liable for the accident and their insurance companies and policy number(s).
	c. <u>Worker's Compensation</u>	Name of the employer, insurance company and policy number.
13.	**Does the recipient intend to file suit?:**	Indicate with an "**x**" mark after "YES" or "NO".
14.	**Date of settlement (if applicable):**	Indicate date suit was settled.
15.	**Name, address and telephone number of recipient's attorney(s):**	Indicate the name of recipient's attorney, address and telephone number.
16.	**Recipient had at the time of accident:**	
	( ) <u>Free No-Fault Insurance</u>	Indicate with an "**x**" mark if recipient has <u>free</u> no-fault insurance. (Bona fide welfare recipients who receive financial assistance from the Department qualify for no fault insurance coverage at no cost upon certification of coverage by a motor vehicle insurance carrier. Attach copy of Certificate of Eligibility, Form HJUP-8).
	( ) <u>Purchased Insurance</u>	Indicate with an "**x**" mark if automobile insurance was <u>purchased</u>. (Motor vehicle insurance was paid by recipient, or by someone else such as parents, in behalf of the recipient).
	Name of Insurance Co., Policy No., and Claim No.:	Indicate the name of the insurance company, policy number and claim number.
	( ) No coverage	Indicate with an "**x**" mark if no coverage.
17.	**Recipient was injured in own vehicle as a:**	
	( ) Driver	Indicate with an "**x**" mark if the recipient was injured as a driver in own vehicle.
	( ) Passenger	Indicate with an "**x**" mark if recipient was injured as a passenger in own vehicle.

	Recipient was injured in another vehicle as a:	
	( ) Driver of borrowed car	Indicate with an "**x**" mark if recipient was injured as a driver of a borrowed vehicle.
	( ) Passenger	Indicate with an "**x**" mark if recipient was injured as a passenger in another vehicle.
	( ) Pedestrian	Indicate with an "**x**" mark if recipient was injured as a pedestrian.
	( ) Other (Explain on Other Information Section 18).	Indicate with an "**x**" mark if different from any of the above situations.
	Name of vehicle owner, Insurance Co., and Policy No.:	Give name of vehicle owner and name of his/her insurance company and policy number.
	Name of driver of vehicle, Insurance company and Policy No.:	Give name of driver of vehicle, insurance company and policy number, if policy number differs from above.
18.	**Police Report:**	Indicate with an "**x**" mark after "Yes" or "None Available". If you mark "Yes", list the report number in the space provided.
19.	**Other information:**	Use this space if additional space is needed to explain any of the above items or to add other pertinent information relative to the accident.
20.	**Worker's Name:**	Self-explanatory
21.	**Date:**	Self-explanatory
22.	**Section/Unit:**	Self-explanatory
23.	**Phone number:**	Self-explanatory

DISTRIBUTION:

1. Original - FMO
2. Second Copy - FMO
3. Third Copy - Case Record