24th Judicial District Court for the Parish of Jefferson
In Re: Nancy Anderson, et al. v. Bob Dean, Jr. et al.

PROOF OF CLAIM FORM

Please see the Class Definition in the Claim Instructions Cover Sheet to determine if you are a member of the Class and can make a claim in this matter. If you are a member of the Class and do not participate in this litigation you will lose the legal right to make a claim against the defendants or recover any money from the class settlement. The Court has a strict deadline of **MAY 15, 2023,** to file a claim in this matter. If, by **MAY 15, 2023,** you fail to complete, sign, and return all required forms, include all requested supporting documents and/or obtain a notary signature where required, your claim will be rejected.

I. CLAIMANT INFORMATION

1. For whom is this claim form being completed?

☐ Resident and/or Personal Representative Represented by Counsel.

☐ Resident and/or Personal Representative Not Represented by Counsel.

2. If you are completing this form on behalf of the Resident, please select your relationship to the Resident (*check all that apply*):

☐ Parent ☐ Tutor/Tutrix

☐ Child ☐ Executor/Executrix

☐ Guardian ☐ Attorney

☐ Spouse ☐ Other: _____

3. Is the Resident deceased?

☐ No ☐ Yes

4. If you are completing this form on behalf of a Resident that is *not deceased*, does the Resident have an active Power of Attorney?

☐ No ☐ Yes

i. If "Yes," please provide the Agent name and telephone number below and attach a copy of the Power of Attorney.

Agent Name: _____

Agent Tel. No: _____

A. <u>Resident Information</u> (*This section applies to the individual Resident that was evacuated to the Waterbury Warehouse Facility prior to Hurricane Ida.)*

Resident First Name | Middle Initial | Resident Last Name | Suffix

Resident Telephone Number | Resident Email

Resident Social Security Number | Resident Date of Birth

Resident Driver's License Number | Resident Driver's License State

Resident's Mailing Address (Number, Street, City, State, Zip Code)

B. <u>Representative Information for Deceased or Incapacitated Residents</u> (*Complete if you are the personal representative of the Resident evacuated to the Waterbury Warehouse Facility if the Resident is a deceased or lacks capacity to complete this form. If you are filing this claim form on behalf of yourself, you do not need to complete this section. If you are an attorney, attorney information shall be completed in Question C, but please include personal representative information in this section, if applicable.)*

Representative First Name | Middle | Representative Last Name | Suffix

Representative Social Security Number | Representative Date of Birth

Representative Driver's License Number | Representative Driver's License State

Representative Telephone Number | Representative Email

Representative Mailing Address (Number, Street, City, State, Zip Code)

C. <u>Primary Counsel Information</u> (*If Represented by Counsel*)

Attorney First Name _____ Attorney Last Name _____ Suffix _____

Law Firm Name _____

Law Firm Mailing Address _____ (Number, Street, City, State, Zip Code)

Law Firm Email Address _____ Law Firm Telephone _____

II. EVACUATION INFORMATION

1. Prior to the Resident's evacuation to the Waterbury Warehouse Facility, where did the Resident live?

- ☐ Uptown Healthcare Center
- ☐ Park Place Healthcare
- ☐ Raceland Manor Nursing Home
- ☐ River Palms Nursing & Rehab
- ☐ Maison De'ville Nursing Home of Harvey
- ☐ Maison De'ville Nursing Home of Orleans
- ☐ St. Elizabeth's Caring, L.L.C (West Jefferson Nursing Home)

2. Please select which days the Resident was physically present at the Waterbury Warehouse Facility (*check all that apply*):

- ☐ August 26, 2021
- ☐ August 27, 2021
- ☐ August 28, 2021
- ☐ August 29, 2021
- ☐ August 30, 2021
- ☐ August 31, 2021
- ☐ September 1, 2021
- ☐ September 2, 2021

3. When the Resident left the Waterbury Warehouse Facility, where were they taken? (*Please provide the name of the facility and the address.)*

Facility Name: _____

Address: _____

III. INJURY INFORMATION

1. Did the Resident suffer *physical* injuries as a result of their evacuation to the Waterbury Warehouse Facility?

☐ No ☐ Yes

i. If "Yes," please check all *physical* injuries that may apply.

☐ Exhaustion ☐ Dehydration ☐ Excessive Heat

☐ Infection ☐ Hunger ☐ Fatigue

☐ Headaches ☐ Bed Sores ☐ Bruises/Fractures/Fall

☐ Other: _____

ii. If "Yes," please describe the *physical* injuries you suffered and why you believe the injuries were caused by the conditions at the Waterbury Facility. Please include any documented diagnoses.

_____

_____

_____

_____

2. If the Resident suffered *physical* injuries as a result of their evacuation to the Waterbury Warehouse Facility, did the Resident receive medical treatment for their *physical* injuries?

☐ No ☐ Yes

i. If "Yes," please attach medical records to support the claim and provide the number of days the Resident received medical treatment for physical injuries.

First Day Treated: _____ Number of Treatment Days: _____

3 . Did the Resident suffer *mental* injuries as a result of their evacuation to the Waterbury Warehouse Facility?

☐ No ☐ Yes

i. If "Yes," please check all *mental* injuries that may apply.

☐ Stress	☐ Anxiety	☐ Depression
☐ Panic Attacks	☐ Flashbacks	☐ Nightmares/Terrors
☐ Irritability	☐ Anger	☐ P.T.S.D
☐ Other: _____		

ii. If "Yes," please describe the *mental* injuries you suffered and why you believe the injuries were caused by the conditions at the Waterbury Facility. Please include any documented diagnoses.

_____

_____

_____

_____

4. If the Resident suffered *mental* injuries as a result of their evacuation to the Waterbury Warehouse Facility, did the Resident receive medical treatment for their *mental* injuries?

☐ No ☐ Yes

i. If "Yes," please attach medical records to support the claim and provide the number of days the Resident received medical treatment for physical injuries.

First Day Treated: _____ Number of Treatment Days: _____

5. Prior to the Resident's evacuation to the Waterbury Warehouse Facility, which of the following describes the Resident's mental and/or physical condition? (*check all that apply*)

☐ Oxygen Supplementation	☐ Catheterization	☐ Incontinence Briefs
☐ Wound Care	☐ Feeding Tube	☐ Insulin Use
☐ Impaired Swallowing	☐ Mobility Aid Use	☐ Deafness/Blindness
☐ Paralysis/Stroke	☐ Colostomy	☐ Developmental Delays
☐ Palliative Care	☐ Dementia	☐ Amputation
☐ Neurodegenerative Disease	☐ Cancer	☐ Bleeding Disorder
☐ Other: _____	☐ Assistance Toileting	☐ Dialysis/Renal Disease

6. Are there other extenuating circumstances that caused the Resident physical or mental damage that were encountered while present at the Waterbury Warehouse Facility?

☐ No ☐ Yes

i. If "Yes," please describe any other extenuating circumstances that you believe should be considered when reviewing the Resident's claim.

_____

_____

_____

_____

_____

III. PROPERTY, MEDICAL RECORDS & RESIDENT TRUST FUND

1. When the Resident left the Waterbury Warehouse Facility, did they receive a copy of their medical records or were their medical records forwarded to their new facility?

☐ No ☐ Yes

2. Did the Resident receive their personal belongings, or were they able to retrieve them after leaving the Waterbury Warehouse Facility?

☐ No ☐ Yes

i. If "No," please describe the missing items, their approximate original cost, and their personal significance. Any claimed items with a value over $25.00 requires proof of purchase.

_____

_____

_____

_____

_____

3. Did the Resident have a Trust Fund Account?

☐ No ☐ Yes

4. Did the Resident receive the balance of their Trust Fund Account following their evacuation?

☐ No ☐ Yes

i. If "No," please provide an estimate of the unreturned balance from the Resident's Trust Fund Account and the source of the funds.

$ _____

Funds Source: _____

_____

_____

_____

IV. MEDICARE, MEDICAID & SOCIAL SECURITY INFORMATION

1. Was the Resident receiving either Medicare, Medicaid, or Social Security Disability Benefits in August of 2021? (*check all that apply and complete number field, if applicable*)

☐ Medicare: _____
Medicare Recipient Number (9 digits)

☐ Medicaid: _____
Medicaid Number

☐ Social Security Disability Benefits

2. Was the Resident at least 62 ½ years of age as of August 29, 2021?

☐ No ☐ Yes

V. DECEASED RESIDENTS

1. Is this claim being brought on behalf of a deceased individual?

☐ No ☐ Yes

i. If "No," do not complete the remainder of this section.

ii. If "Yes," please provide the date of death, cause of death, and place of death, and you must attach a copy of the Death Certificate for the deceased Resident.

Date of Death: _____ Place of Death: _____

Cause of Death: _____

2. Was the Resident's death caused by the conditions at the Waterbury Warehouse Facility?

☐ No ☐ Yes

i. If "Yes," please use the space below to describe why you believe the Resident's death was caused by the conditions at the Waterbury Facility, and please attach medical records or other supporting documentation.

_____

_____

_____

_____

_____

3. Are you making a wrongful death claim on behalf of the deceased Resident?

☐ No ☐ Yes

i. If "Yes," please provide any relevant information regarding the personal representative's relationship to the deceased Resident.

_____

_____

_____

_____

4. **Are you making a survival action claim on behalf of the deceased Resident?**

☐ No ☐ Yes

i. **If "Yes," please provide any relevant information regarding the losses suffered by the deceased Resident prior to their death.**

_____

_____

_____

_____

_____

5. **Was the deceased Resident providing financial support to their spouse and/or children at the time of their death?**

☐ No ☐ Yes

i. **If "Yes," please provide details as to whom the deceased Resident was financially supporting at the time of their death, and the monthly amount of financial support provided. You must attach proof of financial support.**

_____

_____

_____

_____

_____

6. **Did the deceased Resident have a Last Will and Testament at the time of their death?**

☐ No ☐ Yes

i. **If "Yes," you must attach a copy of the Last Will and Testament of the Resident.**

7. Has a succession been opened for the deceased Resident's estate?

☐ No ☐ Yes

i. If "Yes," please attach a copy of any estate/probate/succession documents and include the case number and court information below.

_____ _____

Case Caption Case Number

_____

Court

8. If a succession has been opened for the deceased Resident's estate, has an Executor/Executrix, Administrator/Administratrix, or other representative been appointed by the Court above?

☐ No ☐ Yes

i. If "Yes," please provide the representative name and telephone number below and attach a copy of the appointment order.

Name: _____

Telephone: _____

9. Was the deceased Resident married at the time of their death?

☐ No ☐ Yes

i. If "Yes," please provide the name and telephone number of the deceased Resident's Spouse below.

Spouse Name: _____

Spouse Tel. No: _____

10. Did the deceased Resident have children at the time of their death?

☐ No ☐ Yes

i. If "Yes," please provide the name, telephone number, and age of the deceased Resident's child/children.

_____

_____

_____

AFFIDAVIT

STATE OF LOUISIANA

PARISH OF_____

BEFORE ME, the undersigned authority, personally came and appeared _____ (Resident or Resident's Personal Representative), who, after being duly sworn and advised under penalty of perjury, did depose and say:

That he/she is a person of the full age of majority; that the above and foregoing PROOF OF CLAIM has been completed by him/her voluntarily, and that he/she has completed the foregoing PROOF OF CLAIM as his/her own free act and deed, and that he/she represents that all information provided is true and accurate to the best of his/her knowledge in the presence of the witness whose name appears below. Said claimant does further understand and agree that before receipt of any funds under the settlement agreement she/he must sign a RELEASE OF ANY AND ALL CLAIMS that he/she has arising out of the Hurricane Ida evacuation to the Waterbury facility. The Release is attached to this form for ease of reference.

Thus, done and signed this _____ day of_____, 2023, before me, Notary Public, and the undersigned duly qualified witnesses after a reading of the whole at _____.

_____

Resident or Personal Representative Name

_____

Resident or Personal Representative Signature

_____ _____

Witness Witness

_____

Notary Signature

_____

Notary Name

Notary No./Louisiana Bar No.: _____

Commission Expires: _____