Columbia University circulated a letter to former Hadden patients to notify them of the existence of the settlement fund. Please be advised that three law firms in New York have filed putative class action lawsuits on behalf of former patients, such as yourself, which allege violations of law, including under the Adult Survivors Act and/or New York City's Gender Motivated Violence Protection Law. If you are a former patient of Hadden and experienced some form of abuse by Hadden, we encourage you to consult with an attorney of your choosing to ensure that you understand your rights before proceeding.

Close and Continue

QUESTIONNAIRE

INFORMATION RELATED TO ELIGIBILITY

Are you a former patient of Robert Hadden? *

○ Yes ○ No

Have you previously sued (i.e., commenced litigation against) Columbia University or Columbia University Medical Center or New York Presbyterian Hospital or any affiliated people or entities related to Robert Hadden? *

○ Yes ○ No

Have you retained counsel (i.e., signed an engagement letter) to represent you in litigation related to Robert Hadden against Columbia University or Columbia University Medical Center or New York Presbyterian Hospital or any affiliated people or entities? *

○ Yes ○ No

Have you previously entered into a settlement agreement with Columbia University or Columbia University Medical Center or New York Presbyterian Hospital or any affiliated people or entities related to Robert Hadden? *

○ Yes ○ No

Were you verbally and/or physically abused by Robert Hadden? *

○ Yes ○ No

Where did your medical visits with Robert Hadden take place? (Please check all that apply)

- ☐ 21 Audubon Clinic, 21 Audubon Avenue, New York, NY 10032
- ☐ 16 East 60th Street, New York, NY 10022
- ☐ Vanderbilt Clinic, 622 West 168th Street, New York, New York 10032
- ☐ New York Presbyterian Columbia Campus, 622 West 168th Street, New York, NY 10032
- ☐ Other

What was the primary reason for your medical visits with Robert Hadden? (Please check all that apply)

- ☐ Routine gynecological examination/annual examination
- ☐ Follow-up appointment regarding a gynecological condition
- ☐ Follow-up appointment regarding a breast examination
- ☐ Prenatal care
- ☐ Labor and Delivery with hospital admission
- ☐ Postnatal care
- ☐ Other

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Seattle, WA 98111

QUESTIONNAIRE

CLAIMANT NAME AND CONTACT INFORMATION

First name *

M.I.

Last name *

Other Name(s) Used

Date of Birth *

mm/dd/yyyy

Country *

United States of America

Current Address *

Street Address 2

City *

State *

Please select an option

ZIP Code *

Best phone number to reach you *

Home Mobile Work

Email Address *

How do you prefer we communicate with you? (check all that apply)

- Mail
- Email
- Phone

NOTE: It is important that you inform the Claims Administrator if you change your physical address, email address, or phone number. To review and process your claim we must be able to contact you.

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QUESTIONNAIRE

ATTORNEY
(If Applicable)

Are you being represented by an attorney in this matter? *

○ Yes ○ No

Attorney First Name

Attorney Last Name

Firm Name

Street Address

Street Address 2

City

State

Please select an option

ZIP Code

Office Phone

Mobile Phone

Attorney Email

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QUESTIONNAIRE

INFORMATION RELATED TO MEDICAL LIENS
(Right to Reimbursement)

As part of the claims process, the Claims Administrator will confirm that there are no medical liens related to your injury that must be repaid prior to disbursement of funds to the claimant. This is a mandatory part of the Settlement Fund process, **and your claim will not be reviewed or considered until all documents required to run the medical liens are submitted.**

- The Claims Administrator will confirm that there are no healthcare liens asserted against you related to an injury covered by the settlement with respect to:
  - Medicare Parts A and B;
  - Medicare Parts C and D, including private insurance companies that administer Medicare Parts C and D coverage;
  - State Medicaid; and
  - Military benefits (TRICARE or Veterans Affairs).
- Federal and state law give Medicare, Medicaid, the U.S. Department of Veterans Affairs, TRICARE and other governmental agencies a right to recover some or all of a settlement payment as reimbursement if they paid for medical care related to an injury that is covered by a settlement.
- If it is determined that you are entitled to a distribution **and** there is a medical lien, the Claim Administrator's medical lien resolution specialists will review the lien and attempt to negotiate a resolution.
- The Claims Administrator cannot accept your representation that there are no medical liens and must instead independently verify that there are no medical liens.

Your application will be deemed fully submitted and ready for review by the Claims Administrator only after you have (a) answered all required fields on the questionnaire; (b) submitted the questionnaire online; (c) signed and completed the **Consent and Authorization for Use and Release of Information**; and (d) signed and completed the **Proof of Representation**.

State of residence at time of the treatment by Robert Hadden *

State(s) of residence from date of treatment to present, if different

Gender at time of abuse *

○ Female ○ Male

Please provide your Social Security Number or National ID if you do not have a Social Security Number *

○ SSN ○ National ID

☑ **Do you participate or are you eligible for Medicare Parts A/B?**

Medicare Claim No. (HICN)

☑ **Do you participate or are you eligible for Medicare Part C?**

Name of Plan

Member Number for Plan

Enrollment Date

mm/dd/yyyy

☑ **Do you participate or are you eligible for Medicare Part D?**

Name of Plan

Member Number for Plan

Enrollment Date

mm/dd/yyyy

☑ **Do you participate or are you eligible for Medicaid?**

Medicaid Number

State of Issuance

Enrollment Date

mm/dd/yyyy

Have you been enrolled in a Medicaid program in more than one state?

○ Yes ○ No

What states have you been enrolled in a Medicaid Program?

Are you a veteran or member of the United States Armed Forces?

◉ Yes ○ No

Please answer the following questions related to Department of Veteran's Affairs Healthcare or Prescription Drug Benefits:

Claim Number

Enrollment Date

mm/dd/yyyy

Branch

Sponsor

Sponsor SSN

Treating Facility

Please answer the following questions related to TRICARE Healthcare or Prescription Drug Benefits:

Claim Number

Enrollment Date

mm/dd/yyyy

Branch

Sponsor

Sponsor SSN

Treating Facility

INFORMATION RELATED TO PERSONAL BANKRUPTCY

Between the date of treatment and the date of submission of this claim, have you ever filed for personal bankruptcy or had an involuntary bankruptcy filed against you?

◉ Yes ○ No

Please provide the case number, state where filed, and name used to the extent that you recall.

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SEXUAL ABUSE BY HADDEN

BACKGROUND QUESTIONS

Why did you seek treatment from Hadden:

Describe how you came to learn of Hadden's practice, including whether you were referred to the practice by someone else:

List (a) the approximate number of times that you saw Hadden, and (b) the dates of your visits with Hadden, as best you can recall:

Describe the first encounter you recall having with Hadden:

Were any of your children delivered by Hadden (if so, list their birth dates, their names at time they were born, and their current ages):

Describe whether other individuals were ever present in the treatment room during any of your visits with Hadden:

VERBAL AND SEXUAL ABUSE

List the approximate date when you recall the abuse began:

List the approximate date when you recall the abuse ended:

List your legal name (if different from your current name) and age(s) at the time of the abuse:

Please select the treatment locations where you recall the abuse occurred (check any that apply):

- [ ] 21 Audubon Clinic, 21 Audubon Avenue, New York, NY 10032
- [ ] 16 East 60th Street, New York, NY 10022
- [ ] Vanderbilt Clinic, 622 West 168th Street, New York, New York 10032
- [ ] New York Presbyterian Columbia Campus, 622 West 168th Street, New York, NY 10032
- [x] Other

Please specify additional locations where the abuse occurred

Describe, in as much detail as you can, for each time that it occurred, the nature of the abuse you experienced, including the specific abuse suffered (this is difficult, but these details will be helpful to the Claims Administrator in evaluating your claim):

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SEXUAL ABUSE BY HADDEN

SUPPORT

List all people you can recall who were witnesses to the abuse and when/where they witnessed it:

List (a) all other persons who can support your experience of abuse, and (b) when you informed these individuals about the abuse:

EFFECTS OF ABUSE

Please select and describe, as best you can, the effects that you feel the abuse by Hadden has had on your life, including:

- [x] Physical effects and/or injuries
  - If you sustained any physical injuries related to abuse by Hadden and received treatment for such injuries, list:
  - Any physician or healthcare provider who treated you as a result of the abuse:
  - The dates of treatment:
  - The diagnosis (if any) of the condition for which you were treated:
  - Any amount you paid out-of-pocket for such treatment:
- [x] Psychological effects and/or injuries
  - If you sustained any psychological injuries related to the abuse by Hadden and received treatment for such injuries, list:
  - Any psychiatrist, psychologist, social worker, counselor, or other mental health provider who treated you as a result of the abuse:
  - The dates of treatment:
  - The diagnosis (if any) of the mental health condition for which you were treated:
  - Any amount you paid out-of-pocket for such treatment:
- [x] Economic Effects
  - Description of economic effects (including lost wages)
- [x] Marriage/Interpersonal Relationships, Career, Educational, Family Life Effects
  - Description of the impact of the abuse on your marriage/interpersonal relationships, career, education, family life:

Please list any psychiatrist, psychologist, social worker, counselor, or other mental health provider who treated you prior to the abuse, including the dates of treatment and the diagnosis (if any) of the mental health condition for which you were treated:

Please list any psychiatrist, psychologist, social worker, counselor, or other mental health provider who treated you after the abuse, including the dates of treatment and the diagnosis (if any) of the mental health condition for which you were treated:

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ADDITIONAL INFORMATION

SUPPORT

Other than the occurrences described previously, describe all other contacts you recall having had with Hadden, including any contact you may have had since the abuse:

Describe when you first learned about the allegations involving Hadden:

If you were involved in any criminal investigation of Hadden, describe your role in that investigation:

If you have ever been sexually abused by any individual(s) other than Hadden, please describe the general nature of the abuse, your age at the time of the abuse, the dates, number of times, and details, as best you can:

If you have been a party to any prior lawsuit(s) (whether personal injury or other) please provide all identifying information for each lawsuit or claim:

If you have any other information that you think should be considered in assessing your claim, please provide it here:

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SEXUAL ABUSE BY HADDEN

SUPPORTING DOCUMENTS

Provide any documents (including, but not limited to, photographs, e-mails, and text messages) that support your experience of abuse, as well as any records to support any treatment you have received. Please include any other documentation that you think should be considered in assessing your claim.

Please upload a file in one of the following formats and click "Upload": .bmp, .gif, .jpg, jpeg, .pdf, .png, .tiff, .tif, .doc, .docx, .xls, .xlsx, .csv, .rtf. You may upload files up to 50MB large, up to 500MB total. If you have additional or larger files to provide, please contact us at info@haddensettlementfund.com.

Choose File | No file chosen

Cancel | Upload

SUPPORTING AUDIO OR VIDEO RECORDINGS

Provide any videos or audio recordings that support your experience of abuse here. Please include any other video and audio recordings that you think should be considered in assessing your claim.

Please upload a file in one of the following formats and click "Upload": .mov, .mp3, .mp4, .wav. You may upload files up to 50MB large, up to 500MB total. If you have additional or larger files to provide, please contact us at info@haddensettlementfund.com.

Choose File | No file chosen

Cancel | Upload

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Summary

Contact Information

First name	First Name
Middle Initial	
Last name	Last Name
Other Name(s) Used	
Current Address	Current Address
Street Address 2	
City	City
State	AL
ZIP	99999
Country	US
Best phone number to reach you	(206) 867-5309
Phone Type	Mobile
Email Address	Email_Address@email.com
How do you prefer we communicate with you?	Email

Supporting Documents

File name

Supporting Audio or Video Recordings

File name

In addition to filling out this form, do you wish to have the opportunity to speak directly with the Claims Administrator? This is not mandatory, and any information shared with the Claims Administrator during such a meeting will be kept confidential. (check your response) *

○ Yes ○ No

VERIFICATION

I have reviewed the above responses and confirm that the information provided above is accurate and complete to the best of my current recollection. The parties agree that this document will not be used for any purpose outside of the Settlement Fund, and that it will not be disseminated or re-distributed to the press, the public, or used for purposes of deposition testimony, impeachment, cross examination, or trial testimony, unless required by law. I have endeavored to provide accurate information based on my recollection of the incidents described herein, and I understand that the information I am providing will affect my right to receive a settlement. I further understand that this Questionnaire and any discussions relating to my application to the Settlement Fund will remain confidential for settlement purposes pursuant to Rule 408 of the Federal Rules of Evidence, all state law equivalents, and applicable laws or regulations. I hereby authorize Simone Lelchuk and her authorized agents to review my medical information, only to the extent required to evaluate my claim application and make an appropriate distribution of funds.

I affirm, under the penalties of perjury under the laws of New York, which may include a fine or imprisonment, that the foregoing is true, and I understand that this document may be filed in an action or proceeding in a court of law.

Signature *

Date
04/09/2024 - Eastern Daylight Time

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