Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number – –
Wage Earner (If Different)	Social Security Number – –

Part I

APPOINTMENT OF REPRESENTATIVE

I appoint this person, _____,
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____.
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) –	Fax Number (with Area Code) ( ) –	Date

Part II

ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney who is participating in the direct fee payment demonstration project.

☐ I am a non-attorney . I am not participating in the direct fee payment demonstration project.

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☐ No

I have been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☐ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code) ( ) –	Fax Number (with Area Code) ( ) –	Date

Part III (Optional)

WAIVER OF FEE

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

Part IV (Optional)

WAIVER OF DIRECT PAYMENT

by Attorney or Non-Attorney Eligible to Receive Direct Payment

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Representative Waiving Direct Payment)	Date

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS
(4 Copies: File, Claimant, Representative, ODAR)

WHOSE *Records to be Disclosed*	Form Approved OMB No. 0960-0623
NAME *(First, Middle, Last)*	
SSN - -	Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including*** **, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY	**IF not signed by subject of disclosure, specify basis for authority to sign**
INDIVIDUAL authorizing disclosure	☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**
SIGN ▶	(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP -

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	IF needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. CLAIMANT NAME	CLAIMANT SSN - -	2. WAGE EARNER NAME, IF DIFFERENT
3. CLAIMANT CLAIM NUMBER, IF DIFFERENT - -	4. SPOUSE'S NAME, IF NOT WAGE EARNER	SPOUSE'S CLAIM NUMBER OR SSN - -

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. I have additional evidence to submit. ☐ Yes ☐ No

Name and address of source of additional evidence:

(Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)

7. Do not complete if the appeal is a Medicare issue.
Check one of the blocks:
☐ I wish to appear at a hearing.
☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.
Regardless of the issue you are appealing, you should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc., in No. 9.
I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

8. (CLAIMANT'S SIGNATURE) (DATE)			9. (REPRESENTATIVE'S SIGNATURE/NAME) (DATE)		
ADDRESS			(ADDRESS) ☐ ATTORNEY; ☐ NON-ATTORNEY;		
CITY	STATE	ZIP CODE -	CITY	STATE	ZIP CODE -
TELEPHONE NUMBER ( ) -	FAX NUMBER ( ) -		TELEPHONE NUMBER ( ) -	FAX NUMBER ( ) -	

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION-ACKNOWLEDGMENT OF REQUEST FOR HEARING

10. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)
(Title) (Address) (Servicing FO Code) (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO
If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): _____

14. Check one: ☐ Initial Entitlement Case ☐ Disability Cessation Case ☐ Other Postentitlement Case

16. HO COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII;
☐ Title II CF held in FO ☐ Electronic Folder
☐ CF requested ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII
(Copy of email or phone report attached)

17. CF COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title XVIII
☐ Other Attached: _____

15. Check all claim types that apply:

☐ RSI only	(RSI)
☐ Title II Disability-worker or child only	(DIWC)
☐ Title II Disability-Widow(er) only	(DIWW)
☐ SSI Aged only	(SSIA)
☐ SSI Blind only	(SSIB)
☐ SSI Disability only	(SSID)
☐ SSI Aged/Title II	(SSAC)
☐ SSI Blind/Title II	(SSBC)
☐ SSI Disability/Title II	(SSDC)
☐ Title XVIII	(HI/SMI)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: _____	

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS

SOCIAL SECURITY ADMINISTRATION/OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0277

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)

(Either mail the signed original form to the Appeals Council at the address shown below, or take or mail the signed original to your local Social Security office.)

See Privacy Act Notice

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT
3. SOCIAL SECURITY CLAIM NUMBER – –	4. SPOUSE'S NAME AND SOCIAL SECURITY NUMBER *(Complete ONLY in Supplemental Security Income Case)*

5. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

ADDITIONAL EVIDENCE

If you have additional evidence submit it with this request for review. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. If you request an extension of time, you should explain the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.

IMPORTANT: Write your Social Security Claim Number on any letter or material you send us.

SIGNATURE BLOCKS: You should complete No. 6 and your representative (if any) should complete No. 7. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 7.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

6. CLAIMANT'S SIGNATURE DATE	7. REPRESENTATIVE'S SIGNATURE ☐ ATTORNEY ☐ NON-ATTORNEY
PRINT NAME	PRINT NAME
ADDRESS	ADDRESS
(CITY, STATE, ZIP CODE)	(CITY, STATE, ZIP CODE)
TELEPHONE NUMBER ( ) – / FAX NUMBER ( ) –	TELEPHONE NUMBER ( ) – / FAX NUMBER ( ) –

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

8. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

9. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? ☐ Yes ☐ No

10. If "No" checked: (1) attach claimant's explanation for delay; and
(2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

11. Check one:
☐ Initial Entitlement
☐ Termination or other

APPEALS COUNCIL
OFFICE OF DISABILITY ADJUDICATION AND REVIEW, SSA
5107 Leesburg Pike
FALLS CHURCH, VA 22041 - 3255

12. Check all claim types that apply:

☐ Retirement or survivors	(RSI)
☐ Disability-Worker	(DIWC)
☐ Disability-Widow(er)	(DIWW)
☐ Disability-Child	(DIWC)
☐ SSI Aged	(SSIA)
☐ SSI Blind	(SSIB)
☐ SSI Disability	(SSID)
☐ Title VIII Only	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify: _____	

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS

SOCIAL SECURITY ADMINISTRATION

TOE 850

Form Approved
OMB No. 0960-0104

PETITION TO OBTAIN APPROVAL OF A FEE FOR REPRESENTING A CLAIMANT BEFORE THE SOCIAL SECURITY ADMINISTRATION

IMPORTANT INFORMATION ON REVERSE SIDE

PAPERWORK/PRIVACY ACT NOTICE: Your response to this request is voluntary, but the Social Security Administration may not approve any fee unless it receives the information this form requests. The Administration will use the information to determine a fair value for services you rendered to the claimant named below, as provided in section 206 of the Social Security Act (42 U.S.C. 406).

I request approval to charge a fee of → Fee$ (Show the dollar amount)

for services performed as the representative of →

My Services Began: ____ / ____ / ____ (Month / Day / Year)

My Services Ended: ____ / ____ / ____

Type(s) of claim(s)

Enter the name and the Social Security number of the person on whose Social Security record the claim is based.

___ ___ ___ / ___ ___ / ___ ___ ___ ___

1. Itemize on a separate page or pages the services you rendered before the Social Security Administration (SSA). List each meeting, conference, item of correspondence, telephone call, and other activity in which you engaged, such as research, preparation of a brief, attendance at a hearing, travel, etc., related to your services as representative in this case. Attach to this petition the list showing the dates, the descriptions of each service, the actual time spent in each, and the total hours.

2. Have you and your client entered into a fee agreement for services before SSA? ☐ YES ☐ NO
   If "yes," please specify the amount on which you agreed, and attach a copy of the agreement to this petition. $ _____ and ☐ See attached

3. (a) Have you received, or do you expect to receive, any payment toward your fee from any source other than from funds which SSA may be withholding for fee payment? ☐ YES ☐ NO
   (b) Do you currently hold in a trust or escrow account any amount of money you received toward payment of your fee? ☐ YES ☐ NO
   If "yes" to either or both of the above, please specify the source(s) and the amount(s).
   Source: _____ $ _____
   Source: _____ $ _____
   Note: If you receive payment(s) after submitting this petition, but before the SSA approves a fee, you have an affirmative duty to notify the SSA office to which you are sending this petition.

4. Have you received, or do you expect to receive, reimbursement for expenses you incurred? ☐ YES ☐ NO
   If "yes," please itemize your expenses and the amounts on a separate page.

5. Did you render any services relating to this matter before any State or Federal court? ☐ YES ☐ NO
   If "yes," what fee did you or will you charge for services in connection with the court proceedings? $ _____
   Please attach a copy of the court order if the court has approved a fee.

6. Have you been disbarred or suspended from a court or bar to which you were previously admitted to practice as an attorney? ☐ YES ☐ NO

7. Have you been disqualified from participating in or appearing before a Federal program or agency? ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature of Representative	Date:	Address (include Zip Code)

Firm with which associated, if any	Telephone No. and Area Code

[Note: The following is optional. However, SSA can consider your fee petition more promptly if your client knows and already agrees with the amount you are requesting.]

I understand that I do not have to sign this petition or request. It is my right to disagree with the amount of the fee requested or any information given, and to ask more questions about the information given in this request (as explained on the reverse side of this form). I have marked my choice below.

☐ I agree with the $_____ fee which my representative is asking to charge and collect. By signing this request, I am not giving up my right to disagree later with the total fee amount the Social Security Administration authorizes my representative to charge and collect.

OR

☐ I do not agree with the requested fee or other information given here, or I need more time. I understand I must call, visit, or write to SSA within 20 days if I have questions or if I disagree with the fee requested or any information shown (as explained on the reverse sides of this form).

Signature of Claimant	Date

Address (include Zip Code)	Telephone No. and Area Code

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I-5-1-18. Increased Dollar Cap for Fee Agreements

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III Policy Statement
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ISSUED: June 19, 2009

I. Purpose

This Temporary Instruction supplements instructions in the Hearings, Appeals and Litigation Law (HALLEX) manual, Volume I, Division 1, Chapter 2, to provide Office of Disability Adjudication and Review (ODAR) staff and decision makers with guidance on acting on fee agreements involving the increased dollar cap.

II. Introduction

On February 4, 2009, the Commissioner announced through a Federal Register notice that the dollar cap that a fee agreement may specify will increase from $5,300 to $6,000, effective for fee agreements approved on or after June 22, 2009.

The Social Security Administration (SSA) released an Emergency Message, EM-09006, regarding the fee agreement dollar cap increase on February 12, 2009.

III. Policy Statement

A. .Effective Date of Increased Dollar Cap

The increase in the dollar cap from $5,300 to $6,000 is effective for fee agreements approved on or after June 22, 2009. The controlling event is the date the decision maker acts on the fee agreement, not the date the fee agreement was signed or filed, or the date of the determination/decision on the claim for benefits. (HALLEX I-1-2-12 A. 3, NOTE 1.)

- For fee agreements approved on or after February 1, 2002 and before June 22, 2009, the fee specified in the fee agreement may not exceed the lesser of 25 percent of past-due benefits or **$5,300**.
- For fee agreements approved on or after June 22, 2009, the fee specified in the fee agreement may not exceed the lesser of 25 percent of past-due benefits or **$6,000**.

B. Fee Agreement Language

SSA accepts language in a fee agreement that would apply whether SSA acts on the agreement before, on or after June 22, 2009. The following are examples:

- If SSA favorably decides the claim, I will pay my representative a fee equal to the lesser of 25 percent of my past-due benefits or the dollar amount established pursuant to section 206(a)(2)(A), which is currently $5,300, but may be increased from time to time by the Commissioner of Social Security.
- If SSA favorably decides the claim, I will pay my representative a fee equal to the lesser of 25 percent of my past-due benefits or $5,300 (or such higher amount as prescribed by the Commissioner of Social Security pursuant to section 206(a)(2)(A) of the Social Security Act).
- I will pay my representative a fee equal to 25 percent of any past-due benefits from my claim or, if less, the maximum dollar amount allowed pursuant to section 206(a)(2)(A) of the Social Security Act based on the date SSA approves my fee agreement.

Decision makers may **approve** fee agreements with any of these provisions before June 22, 2009, or on or after June 22, 2009, if they otherwise meet the statutory requirements and are not subject to any exception in I-1-2-12 B. However, the amount SSA authorizes to the representative will depend on whether the fee agreement was approved before June 22, 2009, or on or after June 22, 2009.

C. Fee Agreement Approved – SSA Issues Additional Favorable Decision

The decision maker's approval of a fee agreement can remain in effect for any subsequent favorable decision SSA may issue on the same issue or issues, if there has been no change in pertinent circumstances and if the approval was proper. (HALLEX I-1-2-14 B.)

Accordingly, if a fee agreement was approved in connection with a favorable initial or reconsideration determination or a hearing decision, and an Administrative Law Judge (ALJ) or the Appeals Council (AC) issues a subsequent favorable decision on the same issue or issues, no further action is required on the fee agreement unless the initial fee agreement approval was improper. The component that effectuates the subsequent decision will determine if the representative(s) is due any additional fee based on the subsequent decision.

NOTE: Sometimes SSA issues favorable decisions to the same claimant in more than one type of claim for benefits, e.g., dual entitlement and simultaneous entitlement. Dual entitlement claims usually involve a common issue, e.g., disability based on an individual's own SSN and on the SSN of a parent (disabled adult child claim). In claims involving a common issue, the representative is authorized a single fee for services.

If an SSA decision maker approves a fee agreement that specifies a dollar cap of $5,300 (or less) before June 22, 2009, and SSA issues a subsequent favorable decision on or after June 22, 2009, the terms of the approved fee agreement, including the specified dollar cap of $5,300 (or less), apply to any additional payments to the representative that could result from that agreement.

IV. Procedure

A. Decision Maker Action on a Fee Agreement

Before June 22, 2009, decision makers will approve fee agreements in which the fee specified does not exceed the lesser of 25 percent of past-due benefits or **$5,300** (assuming other statutory conditions are met and no exception applies.)

On or after June 22, 2009, decision makers will approve fee agreements in which the fee specified does

not exceed the lesser of 25 percent of past-due benefits or **$6,000** (assuming other statutory conditions are met and no exception applies.)

B. Representative Submits a Revised Fee Agreement

As a result of the increased dollar cap for fee agreements, ODAR components may receive revised fee agreements. This section provides instructions for receiving, handling, and acting on the revised fee agreement.

1. Receiving and associating the revised fee agreement

a. Document the date of receipt (e.g., date stamp) if it is not already stamped or otherwise date-documented.

b. If the claim is pending, associate the revised fee agreement with the claim folder (whether paper or electronic). See section IV. B. 2. below.

c. If a decision maker issued a favorable decision, forward the revised fee agreement to the decision maker. See section IV. B. 3. below.

d. If a decision maker issued an unfavorable decision, associate the revised fee agreement, or forward it for association, with the claim folder.

e. After a decision maker acts on the revised fee agreement, send a copy of the order, the revised fee agreement, and any other fee-related documents to the effectuating component(s).

NOTE: In concurrent title II and title XVI claims cases, send copies to both the field office and the processing center.

2. Decision maker action - pending claim

a. The decision maker acts on the most recently negotiated and signed fee agreement that SSA received before the date of the favorable decision. (HALLEX I-1-2-12 C. 1.)

b. Based on the terms of the agreement and the date on which the decision maker acts on the agreement (see section IV. A.), the decision maker approves or disapproves the fee agreement.

NOTE: In considering a revised fee agreement, the decision maker must consider, *inter alia*, whether the agreement is between the claimant and the same representative or representatives, i.e., whether the name(s) and signature(s) are all the same as on the earlier agreement. If not, an exception to the fee agreement process may apply. (HALLEX I-1-2-12 B.)

c. If an SSA decision maker previously issued a favorable determination or decision, and in connection with the adjudication, acted on a fee agreement and the action was proper, the decision maker in a subsequent favorable decision on the same issue or issues does not act on the fee agreement. See section III. C. above.

3. Decision maker action – decision maker receives revised fee agreement after the date of the favorable decision

a. The decision maker approves or disapproves the fee agreement. (HALLEX I-1-2-12.) For example, if the agreement is filed with SSA after the date of a favorable decision, the decision

maker disapproves the agreement because it was not filed before the date we made a favorable decision.

b. If an SSA decision maker previously issued a favorable determination or decision and, in connection with that adjudication, acted on a fee agreement, the decision maker in a subsequent favorable decision on the same issue or issues does not act on the revised fee agreement. See section III. C. above.

c. If the decision maker previously approved a fee agreement in association with a favorable decision and is considering a revised fee agreement in association with the same favorable decision, the decision maker must consider whether the revised fee agreement was filed with SSA **before** or **after** the date of the favorable decision that he or she issued.

NOTE: The claimant or representative may have filed a revised fee agreement with SSA before the date the decision maker issued the favorable decision, but the agreement may not have been associated with the file before the date of the favorable decision.

If the revised fee agreement was filed with SSA before the date of the favorable decision, see IV. B. 3. d. below. If the revised fee agreement was filed with SSA after the date of the favorable decision, see IV. B. 3. e. below.

d. If the revised fee agreement was filed with SSA **before** the date of the favorable decision, the decision maker issues an amended order approving or disapproving the revised fee agreement and providing administrative review rights. In approving or disapproving the fee agreement, the decision maker applies the applicable cap as of the date he or she acts on the fee agreement (see I-5-1-18 III. A.). The amended order should specifically state 1) that the previous order of approval is no longer in effect, and 2) the date of the fee agreement that the decision maker is acting on.

e. If the revised fee agreement was filed with SSA **after** the date of the favorable decision, the decision maker disapproves the revised fee agreement and issues the following notice:

> We wrote you earlier to tell you that we approved your fee agreement. We also received a revised fee agreement between you and your representative, dated [date of revised fee agreement]. We did not approve the revised fee agreement because the Social Security Administration did not receive the written agreement before I decided the claim. Therefore, the approval of the earlier fee agreement remains in effect.

C. Administrative Review of the Approval or Disapproval of a Fee Agreement

If a decision maker acts on a fee agreement (including a revised fee agreement), he or she must provide administrative review rights regarding the approval or disapproval. (HALLEX I-1-2-41.)

D. Administrative Review of the Amount of the Fee

The increase in the fee cap is not in and of itself a consideration in deciding whether to affirm or modify the amount of the fee on administrative review in the fee agreement process. The reviewing official will follow the guidelines in HALLEX I-1-2-47 in determining whether to affirm or modify the fee amount.

V. Inquiries

Hearing Office personnel should contact the Regional Office. Regional Office personnel should contact

the appropriate branch in the Office of the Chief Administrative Law Judge. Office of Appellate Operations personnel should contact the Executive Director's Office.

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SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT - APPEAL

For SSA Use Only -
Do not write in this box.

Related SSN _____ - - _____

Number Holder _____

Date of Last Disability Report _____

Individual is filing: ☐ **Reconsideration** ☐ **Reconsideration for Disability Cessation** ☐ **Request for ALJ Hearing**

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME *(First, Middle Initial, Last)*

B. SOCIAL SECURITY NUMBER
- -

C. DAYTIME TELEPHONE NUMBER *(If you do not have a number where we can reach you, give us a daytime number where we can leave a message.)*

( ) _____ - _____ ☐ Your Number ☐ Message Number ☐ None
Area Code *Number*

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim or case.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ _____ _____ - _____ DAYTIME PHONE ( ) _____ - _____
City *State* *ZIP* *Area Code* *Number*

SECTION 2 - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

A. Has there been any change (for better or worse) in your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

_____

_____

_____

Approximate date the changes occurred:

Month	Day	Year

B. Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

_____

_____

_____

Approximate date the changes occurred:

Month	Day	Year

C. Do you have any new illnesses, injuries or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

Approximate date the changes occurred:

Month	Day	Year

If you need more space, use Section 10 - REMARKS.

SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Since you last completed a disability report, have you seen or will you see a **doctor/hospital/clinic** or anyone else for the illnesses, injuries, or conditions that limit your ability to work? ☐ YES ☐ NO

B. Since you last completed a disability report, have you seen or will you see a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

C. List **other names** you have used on your medical records.

If you answered "NO" to both A and B, go to Section 4 - MEDICATIONS.

Tell us who may have medical records or other information about your illnesses, injuries, or conditions **since you last completed a disability report.**

D. List each DOCTOR/HMO/THERAPIST/OTHER. Include your **next appointment.**

1.

NAME			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP** -	**LAST** VISIT
PHONE ( ) - *Area Code* *Phone Number*	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** DID YOU RECEIVE?			

2.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	STATE	ZIP -	**LAST** VISIT
PHONE ( ) - *Area Code* *Phone Number*	PATIENT ID # (if known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** DID YOU RECEIVE?			

If you need more space, use Section 10 - REMARKS.

E. List each HOSPITAL/CLINIC. Include your **next appointment.**

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP -	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE ( ) - *Area Code* *Phone Number*			☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Section 10 - REMARKS.

F. Since you last completed a disability report, does **anyone else have medical records or information** about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else? ☐ YES ☐ NO

If "**YES**," complete information below:

NAME			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP** -	**LAST** VISIT
PHONE ( ) - *Area Code* *Phone Number*			NEXT **APPOINTMENT**
CLAIM NUMBER (if any)			
REASONS FOR VISITS			

If you need more space, use Section 10 - REMARKS.

SECTION 4 - MEDICATIONS

Are you currently taking any **medications** for your illnesses, injuries or conditions? ☐ YES ☐ NO

If "**YES**," please tell us the following: (*Look at your medicine containers, if necessary.*)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Section 10 - REMARKS.

SECTION 5 - TESTS

Since you last completed a disability report, have you had any **medical tests** for illnesses, injuries, or conditions or do you have any such tests scheduled? ☐ YES ☐ NO

If "**YES**," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN WAS/WILL TEST BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY -- Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY -- Name of body part _____			
MRI/CT SCAN -- Name of body part _____			

If you need more space, use Section 10 - REMARKS.

SECTION 6 - UPDATED WORK INFORMATION

Have you worked **since you last completed a disability report?** ☐ YES ☐ NO

If **"YES,"** you will be asked to give details on a separate form.

SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

A. How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

_____

_____

B. What changes have occurred in your daily activities **since you last completed a disability report?**

If none, show "**NONE**." _____

_____

_____

If you need more space, use Section 10 - REMARKS.

SECTION 8 - EDUCATION/TRAINING INFORMATION

Have you completed any type of **special job training, trade or vocational school since you last completed a disability report?** ☐ YES ☐ NO

If "**YES**," describe what type: _____

_____

_____

_____

Approximate date completed: _____

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Since you last completed a disability report, have you participated in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services, to help you go to work? ☐ YES ☐ NO

If "**YES**," complete the following information:

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box, or Rural Route)

_____ - _____

City *State* *ZIP*

DAYTIME PHONE NUMBER ( ) - _____

Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 10 - REMARKS

Use this section for any additional information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.

SECTION 10 - REMARKS

Name of person completing this form *(Please print)*	**Date Form Completed** *(Month, day, year)*
Address *(Number and street)*	**e-mail address** *(optional)*

City	**State**	**ZIP**
		-