Social Security Disability References

- 20 CFR Part 400-499
- USDC Middle District of Pa Rule 83
- Social Security Administration
  240 West Third Street
  Williamsport, PA 17701
  570-323-9856
  323-6560 (Fax)
- Office of Disability Adjudication and Review
  Stegmaier Building
  7 North Wilkes-Barre Boulevard
  Wilkes-Barre, PA 18702
  570-826-6419
  570-821-4169 (Fax)
- SEVERE.net
- Disability Under the Social Security Act© 2008 Edition – See attached order form
- Socialsecurity.gov

ORDER FORM

DISABILITY UNDER THE SOCIAL SECURITY ACT©

2008 EDITION

I would like to order _____ (copy)(copies) of the 2008 Edition of "Disability Under the Social Security Act" @ $50 each. Please send to the following address:

Name:

Organization:

Address:

City, State, Zip:

Phone:

Fax: _____ E-Mail:

How did you learn about our outline?

I have enclosed a check in the amount of $50.00 made payable to "Community Legal Services, Inc."

Mail Order Form to:

Maggie O'Connor
Community Legal Services, Inc.
1424 Chestnut Street
Philadelphia, PA 19102-2505

SOCIAL SECURITY REPRESENTATION FEE AGREEMENT

_____, Client, hereby employs _____, attorney at law, and his/her firm, _____, as attorneys to represent **him/her** in administrative proceedings within the Social Security Administration relating to Client's disability claim.

Expenses of litigation:

Actual expenses incurred on the business of the Client shall be paid by the client.

Attorney fees: Contingent as follows:

Twenty-five percent (25%) of past due benefits or $6,000, whichever is less. This fee is subject to approval by the Social Security Administration. No fee will be charged if the claim is not successfully concluded.

Client acknowledges receipt of a copy of this Agreement.

IN WITNESS WHEREOF, the parties hereto have set their hands and seals this ____ day of _____, 2009.

_____

FIRM NAME

By:_____

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

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; ☐ T 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: _____	

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT-APPEAL

For SSA Use Only
Do not write in the shaded area.
Related SSN Number Holder

Date of Last Disability Report

Claimant 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 have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

( ) ☐ 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.

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

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

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

Month	Day	Year

If you need more space, use Remarks, Section 10.

SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Since you last completed a disability report, have you been 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.

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** SEEN
PHONE *Area Code* *Phone Number*	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

2.

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

If you need more space, use Remarks, Section 10.

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			☐ **OUTPATIENT VISITS** *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP			
			☐ **EMERGENCY ROOM VISITS**	DATE OF VISITS	
PHONE					
Area Code	*Phone Number*				

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 Remarks, Section 10.

F. Since you last completed a disability report, does **anyone else have medical records or information** about your illnesses, injuries, or conditions (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** SEEN
PHONE *Area Code* *Phone Number*			NEXT **APPOINTMENT**
CLAIM NUMBER (If any)			
REASONS FOR VISITS			

If you need more space, use Remarks, Section 10.

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 bottles, if necessary.)*

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

If you need more space, use Remarks, Section 10.

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?

If **"YES,"** please tell us the following: *(Give approximate dates, if necessary.)* ☐ YES ☐ NO

KIND OF TEST	WHEN DONE, OR WHEN WILL IT 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 Remarks, Section 10.

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 Remarks, Section 10.

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 added information you did not show in earlier parts of the form. When you are done 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 Code**

Social Security Administration

Form Approved
OMB No. 0960-0730

Identifying Information for Possible Direct Payment of Authorized Fees

Information About the Claimant

First Name	Middle Name

Last Name	Suffix	Social Security Number
		___-___-____

Wage Earner's Name *if different than above*	Wage Earner's Social Security Number *if different*
	___-___-____

Type of Benefits ☐ Title II (RSDI) ☐ Title XVI (SSI)

Information about You, the Representative

Name	Social Security Number
Jonathan E. Butterfield	196-38-3728

P.O. Box, Street, Apt., or Suite No.	City
442 William Street	Williamsport

State	ZIP Code or Postal Zone	Country
PA	17701	USA

Phone Number (including area code)	Fax Number (optional)
570-326-6505	570-326-0437

Employer Identification Number (EIN), if applicable. If you are representing the claimant(s) as a partner or an employee of a firm or other business entity, you may provide the EIN of the firm or business. See instructions on Page 2 for more information.

23-2789-32

Information about Other Claimants You are Representing in Connection with this Claim

List below the Social Security Numbers and names of all other claimants not mentioned above. If all claimants will not fit on this form, list on a separate form or blank paper.

Claimant's Social Security Number	Claimant's Name
___-___-____	
___-___-____	
___-___-____	
___-___-____	
___-___-____	

To SSA STAFF: After the information on this form is entered into the appropriate system(s), immediately shred the form. Under no circumstances should this form be scanned, placed in a claims file or otherwise retained.

IMPORTANT INFORMATION

Purpose of Form

An attorney or other person who wishes to charge or collect a fee for providing services in connection with a claim before the Social Security Administration (SSA) must first obtain approval from SSA. The request for appointment is generally made using the SSA-1696-U4, Appointment of Representative, or equivalent written statement. An attorney or other person who wishes to receive direct payment of authorized fees from SSA must have completed an SSA-1699, Request for Appointed Representative's Direct Payment Information, in order to provide the identifying information that will be used to process these direct payments, including the possible use of direct deposit to a financial institution, and to meet any requirements for issuance of a Form 1099-MISC. It is important to complete a new SSA-1699 whenever there are changes to identifying information. In addition, an attorney or other person must complete this SSA-1695, Identifying Information for Possible Direct Payment of Authorized Fees, for each claim in which a request is being made to receive direct payment of authorized fees.

Instructions for Completing the Form

Claimant Information--Please provide the Social Security Number (SSN) and name of the claimant that you will represent before SSA.

Wage Earner Information--If the claim is being filed on the Social Security record of someone other than the claimant, please provide the SSN and name of that wage earner.

Type of Benefits Information--Please specify the type of benefits for which you are representing the claimant(s).

Representative Information--Please enter your SSN and name as shown on your Social Security card and your mailing address. If you have changed your last name (e.g., due to marriage), please contact your local SSA office to make this change to your Social Security record. In addition, if you are representing the claimant(s) as a partner or employee of a firm or other business entity, you may provide the EIN of that entity. This will allow SSA to issue a Form 1099-MISC to that entity to reflect that the direct payment of authorized fees you receive is actually income to that entity for tax purposes.

Information About Other Claimants--If you are representing other claimants in this claim that are not mentioned above, please provide their SSNs and names. If there are more than five individuals, please provide this information on a separate attachment to this form.

Privacy Act Notice

We are required by section 206(a) and 1631(d) of the Social Security Act to ask you to give us the information on this form. The information is needed to facilitate direct payment of authorized fees and to meet the reporting requirements of the law. Although responses to the questions are voluntary, failure to provide answers to the questions on this form will result in nonpayment for your service.

The information obtained on this form is almost never used for any purpose other than that stated above. However, sometimes the law requires us to disclose the facts on this form without your consent. For example, we must release this information to another person or government agency if federal law requires that we do so or to contractors, as necessary, to assist SSA in the efficient administration of its programs.

Explanations about the reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** You may send comments on our time estimate above to SSA, 6401 Security Boulevard, Baltimore, MD, 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

What You Can Do Online @ *www.socialsecurity.gov*

Apply for benefits	
Apply for Social Security retirement/spouse's benefits	***www.socialsecurity.gov/applyforbenefits***
Apply for Social Security disability benefits	***www.socialsecurity.gov/applyfordisability***
Apply for extra help with your Medicare prescription drug costs	***www.socialsecurity.gov/i1020***
Check the status of your online application	***www.socialsecurity.gov/applyforbenefits***
See if you qualify for benefits	
Find out what benefits you can apply for	***www.socialsecurity.gov/best***
Find out if you can get extra help with your Medicare prescription drug costs	***www.socialsecurity.gov/i1020***
Estimate your future benefits	
Get a personalized retirement benefit estimate	***www.socialsecurity.gov/estimator***
Use our benefit planners to calculate your retirement, disability and survivors benefits	***www.socialsecurity.gov/planners***
Request a *Social Security Statement*	***www.socialsecurity.gov/statement***
If you get benefits	
Change your address or telephone number	***www.socialsecurity.gov/coa***
Get a replacement Medicare card	***www.socialsecurity.gov/medicarecard***
Request a Proof of Income letter	***www.socialsecurity.gov/beve***
Get a Form 1099/1042S —*Social Security Benefit Statement*	***www.socialsecurity.gov/1099***
Get a password	***www.socialsecurity.gov/password***
If you have a password	
Check your information and benefits	***www.socialsecurity.gov/pcyb***
Change your address or telephone number	***www.socialsecurity.gov/coa***
Start or change direct deposit	***www.socialsecurity.gov/pdd***

www.socialsecurity.gov

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