C A S E Y C O X , E S Q .
A T T O R N E Y - A T - L A W

PO Box 730
Camas, WA 98607
Phone: 800-457-3683
Fax: 877-221-3172
law.casey@gmail.com
CaseyCoxLaw.com

NEW CLIENT – WELCOME LETTER

Thank you for entrusting me with handling your Social Security disability claim. I am very excited to work with you and find it an honor to work on your case. I will perform diligently to ensure you get the best representation possible, which will include filing your paperwork on time and accurately, and returning your phone calls promptly. You can call me anytime to update me on your medical status, or to get an update from me about your claim – you will always reach me directly, I don't hide behind a secretary screening my calls. However, my office does not represent you and will not be taking any action on your disability claim until I have received the paperwork back from you.

To get started, please sign/date and complete the enclosed forms, and return them ASAP by fax or scan/email if possible, otherwise by mail. If signing electronically (if you received this packet by email), you will need to use a stylus or your finger to sign -- digital signatures will not match your authentic signature and will be rejected by SSA and medical providers. Otherwise, please print this packet and sign using a blue or black pen.

The Fee Agreement form explains that you will NOT owe me any hourly billing charges and I will only get paid on your claim if we are successful in winning your claim. SSA will pay me only 25% of your backpayment, and you will get 100% of all future payments – or, if you are approved but without any backpayment owed to you, I will file a fee petition for the hours put in on the case, and SSA will have to approve that fee. Please call with any questions.

You can anticipate the process going forward to go as follows: for initial decisions after filing your application, 6-8 months for a decision; for "reconsideration" decisions if an initial decision needs to be appealed, 2-4 months for a decision; and if denied a second time, then an additional 7-10 months before your administrative hearing before a judge.

Notice Regarding Your Claim for SSI (Supplemental Security Income)
If you are approved for SSI, you may be contacted by SSA directly to obtain information about your income, assets, and expenses during the period of your disability. **Please keep in mind that if anyone paid any of your expenses or otherwise loaned you money which you will be repaying pursuant to a loan agreement after you receive your SSI benefits, then you should tell the SSA representative that the money was a loan. You will be required to provide SSA documentation of that loan and I can assist you with that.** If there was no intention to repay the money, however, then the money or assistance will be treated as income to you and will reduce your SSI.

DISCUSSING YOUR CASE WITH OTHERS
It is best to avoid discussing the details of your case with anyone outside of your immediate family or doctor's office. The things you say might be used as admissions against you at a later time. If you are contacted by anyone at SSA or Disability Determination Services, be sure to tell them to call your attorney first, that you have been advised to have all communications first go through him.

FOLLOW THE ADVICE OF YOUR DOCTOR
Please follow the advice of your doctor, and if you cannot, call me to discuss. Getting regular medical and/or mental health treatment is crucial for winning your claim, so please let me know if you are unable to do this.

Please keep track of all medical providers that you see, from referrals, to one-time

WORKING WHILE WAITING FOR DISABILITY
SSA does allow an individual to work and still be eligible for disability, but not in all circumstances. If you are working under the monthly Substantial Gainful Activity (SGA) amount, you most likely will be ok, but not always, so I advise you to call me if you plan on working so we can discuss things first.

If you have any questions, please do not hesitate to contact me.

Again, thank you for appointing me as your representative, and I look forward to working with you.

Sincerely,
Casey A. Cox /s/
Casey Cox
Attorney, Oregon Bar

Claimant's Social Security Number	Appointed Representative's Rep ID
	Q T W 3 S W G H 4 5

Claimant's Appointment of a Representative

Section 1 - Claimant's Information

First Name	Initial	Last Name

Mailing Address

City	State	ZIP/Postal Code	Country - if outside the U.S.

Phone Number		Alternate Phone Number (Optional)	
Country/Area Code	Phone Number	Country/Area Code	Phone Number

Number Holder's Information *(Complete when applicable)*

My claim is based on another person's work or earnings (e.g., spouse or parent). This person's information is different from mine.

Number Holder's Social Security Number

- -

First Name	Initial	Last Name

Section 2 - Disclosure *(Claimant Only)*

☒ By selecting this box, I, the claimant listed in Section 1, whose signature appears in Section 8, authorize SSA to release information in relation to my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g., clerks, assistants), partners, or parties under contractual arrangements for or with my representative. *(The appointed representative's partners, associates, delegates and designees must be prepared to provide information in order to be authenticated.)*

Section 3 - Principal Representative *(Claimant only – Complete when applicable)*

I have appointed before, or appoint now, more than one representative. I ask SSA to make contacts or send notices to this individual. My principal representative is:

Name CASEY A. COX

Claimant's Social Security Number

Appointed Representative's Rep ID
Q T W 3 S W G H 4 5

Section 4 - Representative's Information *(Claimant and Representative)*

Representatives who are eligible and seek direct payment of their fee must register and receive a Rep ID before the appointment. For more information about registration visit us on-line at www.socialsecurity.gov/ar, contact us at 1-800-772-1213 (TTY 1-800-325-0778), or visit your local Social Security office.

First Name	Initial	Last Name
CASEY	A	COX

Mailing Address

PO BOX 730

City	State	ZIP/Postal Code	Country - if outside the U.S.
CAMAS	WA	98607	

Phone Number

503 (Country/Area Code) 828-9908 (Phone Number)

Alternate Phone Number (Optional)

FAX = 877-221-3172

Country/Area Code Phone Number

Section 5 - Representative's Status, Affiliations, and Certifications *(Representative Only)*

Representative's Status Part A - Type of Representative (Representatives have a duty to keep their information current)

- [X] I am an attorney *(SSA law states that an attorney is someone in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)*
- [ ] I am a non-attorney eligible for direct payment *(SSA law requires that non-attorneys meet certain criteria to qualify for direct payment. Refer to our website at www.ssa.gov/representation for criteria).*
- [ ] I am a non-attorney not eligible for direct payment.

- [ ] I work for a non-profit organization (e.g. a law clinic or state legal aid)

Representative's Status Part B - Disqualification

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice law.

- [ ] Yes [X] No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency.

- [ ] Yes [X] No

Claimant's Social Security Number

Appointed Representative's Rep ID

Q	T	W	3	S	W	G	H	4	5

Section 5 - Continued *(Representative Only)*

Affiliation Information

If you are representing the claimant(s) as a partner or employee of a business entity, firm or other organization you may provide your Employer Identification Number (EIN) here, if one exists for tax purposes. This number is not your Social Security Number (SSN). This is your employer's tax identification number. (*Do not complete this section if you do not qualify for direct payment.*)

EIN __ __ - __ __ __ __ __ __ __ SOLE PROPRIETOR

Organization's Name (Enter the full name of the business, entity, firm or organization with which you want to be affiliated while representing this claim)

CASEY A. COX

Representative's Business Address (if different than mailing address)

PO BOX 730

City	**State**	**ZIP/Postal Code**
CAMAS	WA	98607

Country - if outside the U.S.

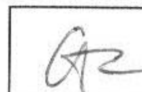
Representative's Certifications

I accept this appointment and certify the following:

- I understand and agree that I will comply with SSA's laws and rules on the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives; I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies.
- I understand that if I fail to comply with any of SSA's laws and rules I may be suspended or disqualified as a representative before SSA.
- I will not disclose any information to any unauthorized party without the claimant's specific written consent.
- I am not currently suspended or prohibited, for any reason, from practicing before the Social Security Administration.
- I am not disqualified from representing the claimant as a current or former officer or employee of the United States.
- I accept appointment as the representative for the claimant named in Section 2 of this form in connection with the claims and asserted rights described in Section 6 of this form.
- I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original.
- I declare under penalty of perjury that I have examined all of the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

If I intend to seek direct payment of the authorized fee on this claim -

- I have registered for and obtained a Rep ID, and my registration information is up-to-date.
- I have provided up-to-date information on my registration concerning whether I have been suspended or prohibited from practice before SSA or any other Federal program or agency, disbarred or suspended by a court or bar, and convicted of a violation under Section 206 or 1631(d) of the Social Security Act.

I CERTIFY TO ALL OF THE ABOVE  *(Representative's Initials)*

Claimant's Social Security Number	Appointed Representative's Rep ID
	Q T W 3 S W G H 4 5

Section 6 - Claim Type *(Claimant or Representative)*

I appoint the individual named in Section 4 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), and Title VIII (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (*Check all that apply*)

- ☐ Claim/Appeal for Title II Disability Benefits
- ☐ Claim/Appeal for Title XVI Disability Benefits
- ☐ Concurrent Title II and Title XVI Disability Benefits
- ☐ Claim/Appeal for Retirement Benefits
- ☐ Claim/Appeal for Title XVIII (Medicare), VIII (Special Veteran's Benefits)
- ☐ Continuing Disability Review (CDR)
- ☐ Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

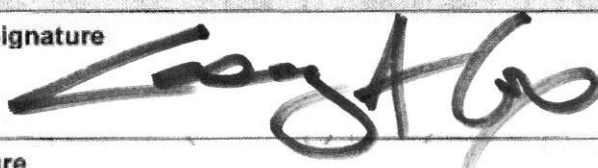
(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

Section 7 - Fee Arrangement *(Representative Only)*

Check one box below:

- ☒ **I will request a fee and direct payment of this fee**. Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. *(We must authorize the fee.)*
- ☐ **I will request a fee but not direct payment.** Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. *(We must authorize the fee.)*
- ☐ **I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual.** Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. *(We do not need to authorize the fee if all regulatory conditions apply.)*
- ☐ **I waive the right to a fee.**

Section 8 - Signatures *(Claimant and Representative)*

Representative's Signature	Date
	
Claimant's Signature	**Date**

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** Casey Cox, Esq.

***ADDRESS OF PERSON OR ORGANIZATION:** PO Box 730, Camas, WA 98607

***I want this information released because:** representation of my disability claim

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date ____________ to date ____________
5. ☐ My Medicare entitlement from date ____________ to date ____________
6. ☐ Medical records from my claims folder(s) from date____________ to date____________

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** ______________________ ***Date:** ____________

****Address:** ______________________ ****Daytime Phone:** ____________

Relationship (if not the subject of the record): ____________ ****Daytime Phone:** ____________

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize ____ LEAVE BLANK ________________________________ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Name: **Date of Birth:** _ _ / _ _ / _ _ _ _

This information is to be disclosed to:

CASEY COX, ESQ.
PO BOX 730
CAMAS, WA 98607
P: 503-866-7979 F: 877-221-3172

This information is disclosed for the following purposes:

X Legal ☐ Insurance ☐ Personal

The type and amount of information to be used or disclosed is as follows from ________ to _________

- X Complete Records
- ☐ Medication List
- ☐ Laboratory results
- ☐ Physical Therapy reports
- ☐ Emergency reports
- ☐ X-ray and imaging reports
- ☐ Consult
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Other ____________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:
365 days from the date of signature below, or at any time and by any means by the patient.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me unless such use or disclosure is specifically required or permitted by law.

A photocopy or fax of this release shall have the same authority and affect as the original.

NOTICE TO RECIPIENTS OF THIS INFORMATION: If these records contain information about HIV/AIDS/STDs you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR pt 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person whom it pertains or otherwise permitted by 42 CFR part 2. A general authorization for the release of medical information is not sufficient for this purpose. The federal rules restrict any any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient."

XX____________________________________ ______________________
Signature of Patient or Legal Representative Date

____________________________________ ______________________ __________
If Signed by Legal Representative, Relationship to Patient Signature of Witness Date

FEE AGREEMENT

I, ___________________, hereby retain and employ CASEY COX, ATTORNEY-AT-LAW (hereinafter "CASEY COX") to represent me in my claim for Disability Benefits under the Social Security Act, including Social Security Disability (SSDI) benefits and/or Supplemental Security Income (SSI) benefits. If the claim is decided favorably and this agreement is approved by the Social Security Administration, I will pay my representative a fee equal to 25% of the past-due benefits due me and my family resulting from my claim(s) up to the maximum fee allowed pursuant to POMS GN 03920.006 ($7,200 max as of 11/30/22) whichever is less and I understand that if the past-due benefits do not exceed $7,2000, the representative may seek administrative review of the amount that would otherwise be the maximum fee.

Representative fees are calculated before deduction for costs and expenses advanced by CASEY COX. I will not pay any representative fees UNLESS my claim is decided in my favor.

***

If the claim progresses to the Appeals Council or Federal Court levels, I agree to pay a fee of 25% of my past due benefits, even if that amount is greater than the amount set forth in POMS GN 03920.006 . In that event, Casey Cox would be required to submit a petition for fees to the Social Security Administration and/or Federal Court, and a copy of the same will be sent to the client. The amount of the fee would require approval by SSA.

***

***

If I, the claimant, am awarded benefits, and there are no past-due benefits available, CASEY COX may file a fee petition for services provided. I understand that my representative cannot collect a fee unless it is approved by the Social Security Administration.

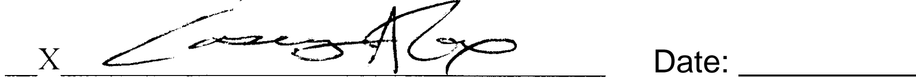
IN WITNESS WHEREOF, CLIENT AND CASEY COX HAVE DULY EXECUTED

CLIENT

_X_____________________________________

Name:___________________ SSN: _____________ Date: ___________

CASEY COX, ATTORNEY-AT-LAW



__X____________________________________ Date: ___________

Name: CASEY COX

PO BOX 730, CAMAS, WA 98607

HITECH Act Medical Records Request

RE:
DOB:

Records Requested:

- LEAVE BLANK

I have enclosed a medical release form for your records.

I am requesting these records pursuant to 45 CFR 164.524. Please be aware that, pursuant to the HITECH Act, this records request must be acted upon within 30 days of receipt of this letter. A failure to do so subjects the entity to the possibility of fines and penalties from the Office of Civil Rights of the U.S. DHHS.

I am requesting the records in electronic format, preferably in un-encrypted PDF format, not paper copies. The HITECH Act does not allow an entity to bill for paper copies when an electronic copy is kept by the entity and is requested by the patient. However, if the records are only available in paper copy format, please call first for pre-payment authorization before sending the records – failure to obtain pre-authorization for billing waives the entity's right to collect payment.

I am choosing per my right established by the HITECH Act to have the records sent to a designated individual. (45 CFR 164.524(c)(3)(ii)). Please send the records to:

Casey Cox, Esq., by fax at 877-221-3172, or by email to Law.Casey@gmail.com

If you have any questions, please feel free to contact me at (503) 866-7979. Thank you for your cooperation.

Sincerely,

____________________________ _______________

Signature Date

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
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

INDIVIDUAL authorizing disclosure

SIGN u

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) u

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 u	**IF** needed, second witness sign here (e.g., if signed with "X" above) **SIGN** u
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
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 **CLAIMANT'S APPOINTMENT OF REPRESENTATIVE**

I appoint this individual, CASEY COX, PO BOX 730, CAMAS, WA 98607
(Name and Address)

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

[X] Title II (RSDI) [X] Title XVI (SSI) [ ] Title XVIII (Medicare) [ ] Title VIII (SVB)

This individual 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).

[X] 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 principal representative is:

(Name of Principal Representative)

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

Part II **REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT**

I, CASEY COX, 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: [X] I am an attorney. [ ] I am a non-attorney eligible for direct payment under SSA law.
[ ] I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. [ ] YES [x] NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. [ ] YES [x] 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 PO BOX 730 CAMAS, WA 98607	
Telephone Number (with Area Code) 503-866-7979	Fax Number (with Area Code) 877-221-3172	Date

Part III **FEE ARRANGEMENT**
(Select an option, sign and date this section.)

[X] **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

[ ] **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

[ ] **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

[ ] **I am waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Form SSA-1696-U4 (07-2014) ef (07-2014)
Use Prior Editions Until Exhausted

FILE COPY

PART 8 - IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The Social Security Administration will check your statements and compare its records with records from other state and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount. We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

PART 9 - SIGNATURES

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. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

Your Signature (First name, middle initial, last name) (Write in ink.)	Date (MM/DD/YYYY)

Spouse's Signature (First name, middle initial, last name) (Write in ink.) (Sign only if applying for payments.)

If you are blind or visually impaired, check the type of mail you want to receive from us

- ☐ Standard notice First-Class
- ☐ Standard notice & data CD by First-Class
- ☐ Standard & Braille notices by First-Class
- ☐ Standard notice & audio CD
- ☐ Standard notice First-Class with a follow-up phone call
- ☐ Standard notice Certified
- ☐ Standard & large print notices

WITNESSES

Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing, who know you, must sign below giving their full address.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

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. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF APPLICANT	Date (Month, Day, Year)
Signature (First name, middle initial, last name) (Write in ink)	Telephone Number(s) at which you may be contacted during the day. (Include the area code)

DIRECT DEPOSIT PAYMENT INFORMATION (FINANCIAL INSTITUTION)

Routing Transit Number	Account Number	☐ Checking ☐ Savings	☐ Enroll in Direct Express ☐ Direct Deposit Refused

Applicant's Mailing Address *(Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)*

City and State	ZIP Code	County *(if any)* in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State and ZIP Code)*	Address *(Number and street, City, State and ZIP Code)*

FOR ATTORNEY TO COMPLETE:
DLI =
AOD =
PFD =
PIA =
FAM MAX =

NEW CLIENT INFO
Please Complete Each Empty Field Below

SECTION ONE:

Name (first/middle/last):

Phone:

Mailing Address:

Physical Address Where You Live:

Email:

DOB:

SSN:

Height/Weight:

Alternate Point of Contact (Name / Phone / Address):

Have You Applied For or Been Denied Benefits In Last 60 Days?:

Have you previously applied for SSI or SSDI at any time in the past? When?:

City & State Where You Were Born:

Maiden Name:

Mother's Maiden Name:

Father's First and Last Name:

Highest Grade of High School Completed: ______
Year Completed: ___________
Name of High School: ____________________
City/State of High School: ______________________
What grades did you attend special education or have an IEP? _____________________________

Level of College Completed: ________________________
Degree Obtained: ___________________________
Name and Location of College: ____________________________

Any vocational or trade school degrees? ____
Year obtained? ___________________

Did you get injured at work at your last job? ______________
Do you have an open and pending workers compensation claim currently? ____________
If not currently, have you had any workers compensation claims since the date ? ___________

Are you a widow of a marriage that lasted 10 years or more?:

CURRENT MARRIAGE:

1. **NAME OF SPOUSE:**
2. **SPOUSE'S DATE OF BIRTH:**
3. **SPOUSE'S S.S.N.:**
4. **DATE OF MARRIAGE:**
5. **CITY AND STATE WHERE MARRIAGE OCCURRED:**
6. **MARRIAGE TYPE (ie, COMMON LAW, CLERGY/OFFICIAL, OTHER):**

PAST MARRIAGE(S) THAT LASTED 10 YEARS OR MORE:

1. **NAME OF SPOUSE:**
2. **SPOUSE'S DATE OF BIRTH:**
3. **DATE MARRIAGE BEGAN:**
4. **DATE MARRIAGE ENDED:**
5. **REASON MARRIAGE ENDED (ie, DEATH, DIVORCE):**
6. City/State of marriage: _____________ City/State marriage ended: _________________

NAMES AND AGES OF ALL CHILDREN AGE 18 OR YOUNGER THAT ARE STILL IN SCHOOL:

Your Medications (including dosage):

Your Health Conditions That Impact Ability To Work:

Date You Believe You Became Unable To Work Full-time:

Did you have to make changes to your work prior to this date?
If "yes", what changes and when did those changes begin?

Have you received money from your employer after the date you last worked?
If "yes", how much, and what for?

Amount Of Income Earned This Year:

Amount Of Income Earned Last Year:

Have You Worked Outside the U.S. In Past 15 Years (non-military)?

Direct Deposit Info (checking acct # and routing #, if you want benefits direct deposited):

SECTION TWO

Provide a List of Your Medical Providers and Treatment (clinics, hospitals, specialty visits, etc) AFTER _______________:

NAME OF DOCTOR OR CLINIC/HOSPITAL	ADDRESS / PHONE	WHEN DID YOU FIRST GO TO THIS PROVIDER?	TYPE OF TREATMENT RECEIVED
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

List Any Other Treatment BEFORE (________) That Is Relevant And Should Be Considered by SSA:

Name Of Clinic/Hospital/Doctor	Address or City/State	Phone/Fax	Reason For Treatment Here
1)			
2)			
3)			
4)			

SECTION THREE: WORK HISTORY FOR PAST 15 YEARS

Please provide a list of each TYPE of job you have had in the past 15 years. Include the following information: (a) month and year you BEGAN and ENDED that type of job, (b) your hourly wage upon leaving, (c) average hours per week worked. (see a,b,c below and use these as your guide)

For example, if you worked as a cook at 10 different restaurants and as a truck driver for 2 different employers, all in the past 15 years, you would provide only TWO jobs here: cook, truck driver

JOB TYPE ONE JOB TITLE: ____________________ **NAME OF EMPLOYER: ________________________**

CITY WHERE JOB WAS WORKED: ________________

(a)

(b)

(c)

JOB TYPE TWO JOB TITLE: ____________________ **NAME OF EMPLOYER: ________________________**

CITY WHERE JOB WAS WORKED: ________________

(a)

(b)

(c)

JOB TYPE THREE JOB TITLE: ____________________ **NAME OF EMPLOYER: ________________________**

CITY WHERE JOB WAS WORKED: ________________

(a)

(b)

(c)

JOB TYPE FOUR JOB TITLE: ____________________ **NAME OF EMPLOYER: ________________________**

CITY WHERE JOB WAS WORKED: ________________

(a)

(b)

(c)

JOB TYPE FIVE JOB TITLE: ____________________ **NAME OF EMPLOYER: ________________________**

CITY WHERE JOB WAS WORKED: ________________

(a)

(b)

(c)

JOB TYPE SIX JOB TITLE: ____________________ **NAME OF EMPLOYER: ________________________**

CITY WHERE JOB WAS WORKED: ________________

(a)

(b)

(c)