LAW OFFICE
OF
GREGG M. HOBBIE

GREGG M. HOBBIE
MEMBER N.J. & PA. BARS

30 Years of Service
1990 - 2020

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MAILING ADDRESS
P.O. BOX 997
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CLAIMANT:

RE: SOCIAL SECURITY DISABILITY ATTORNEY FEE AGREEMENT

This letter will confirm our office discussion. As I explained to you, if you wish my office to represent you on your application/appeal in this matter, our fee will be a contingent fee of 25% of any back due benefits awarded to you and your family, or $6000 whichever is less.

If no benefits are awarded, you will not be charged a fee for our services. You also understand that any fee I may charge you is subject to approval by the proper department of government. This agreement does not include any fees, which may be awarded pursuant to the Equal Access to Justice Act, or if required by a fee petition. I do not pay for medical records.

You understand also that there is no guarantee that you will be successful on your matter. It is my opinion, however, that whether you proceed with my counsel or with another lawyer, or even on your own behalf, you should proceed with your application/appeal in this matter. Please do not delay. If you delay the filing of your application/appeal, you may at some point be barred from bringing it. You understand my offer to represent you is limited to proceedings through the decision of the Administrative Law Judge (ALJ). Whether my office will make an appeal of the ALJ's decision is to be determined exclusively by my office. Further, I reserve the right to withdraw from and terminate my representation at any time it appears to me continuation of the representation is not warranted.

If the above properly sets forth our agreement, please enter date and signature below and return the signed copy of this agreement to my office. A return envelope is enclosed for your convenience. The copy of the agreement is for your records. I look forward to working with you on your application/appeal.

DATE:_____ CLAIMANT: X_____

DATE:_____ REPRESENTATIVE _____

Claimant's Social Security Number

			-			-				

Appointed Representative's Rep ID

7	G	C	W	7	7	N	Z	X	S

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**
X	

Whose Records to be Disclosed

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

SSN | Birthday *(MM/DD/YYYY)*

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 Signature

X

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)

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:*

Signature | **IF** needed, second witness sign here (e.g., if signed with "X" above)

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.

HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO PL2019 CHAPTER 217

To: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

via telex

Re: Patient Name: _____
Date of Birth: _____

I authorize and request the disclosure of all protected information for the purpose and review and evaluation in connection with a Social Security Disability Claim. I expressly request a full and complete copy of my medical records for the dates of service _____ to _____ including all hospital records, physician notes and records as well as any test results, chart notes. I understand the information to be released or disclosed may include information relating to sexual transmitted diseases, Acquired Immune Deficiency Syndrome or Human Immunodeficiency Virus and alcohol and drug abuse. I authorize the release or disclosure of this type of information, this protected health information is disclosed for the purpose of my Social Security Disability Claim.

You are authorized to release the above records to the following representative, Gregg M. Hobbie, Esquire, P.O. Box 997, Eatontown, New Jersey 07724. 732-766-5682 Email address: hobbielaw@gmail.com. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until 2 years from the date of execution at which time this authorization expires.

Date

X _____

SOCIAL SECURITY DISABILITY APPLICATION INTAKE FORM

(Only complete for new claims, not required for appeals.)

1. Name
2. Address
3. Phone number
4. Social Security number
5. Date of birth
6. Place of birth (town and state)
7. Marital status
8. Date and location of marriage
9. Spouses name and age

9a. Names of children under 18
9b. Any disabled children

10. Previous disability applications
11. Highest grade in school and the name and location of that school
12. Date last worked, job title, and salary
13. Work history, past 15 years (including employer's names)
14. Doctor who supports disability claim, including phone number and address.
15. List of disabilities
16. List of medications
17. Height and weight
18. Date disability began (last date of work) or dates of short-term disability
19. Citizen status
20. Military service
21. Workers' compensation involved?
22. Any outstanding felony warrants?