LAW OFFICE
OF
GREGG M. HOBBIE

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

20 Years of Service
1990 - 2010

12 CHRISTOPHER WAY
SUITE 200
P.O. BOX 997
EATONTOWN, N.J. 07724
E-MAIL HOBBIELAW@AOL.COM

(732) 544-1100
FAX (732) 544-8422
MOBILE (732) 766-5682
MAILING ADDRESS
P.O. BOX 997
EATONTOWN, N.J. 07724

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.

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:_____

DATE:_____ REPRESENTATIVE:_____

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, **GREGG M HOBBIE ESQ PO BOX 997 EATONTOWN NJ 07724**
(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, **GREGG M HOBBIE ESQ**, 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 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 ☒ NO

I am now or have previously 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 **PO BOX 997 EATONTOWN NJ 07724**	
Telephone Number (with Area Code) **(732) 544 1100**	Fax Number (with Area Code) **(732) 544 – 8422**	Date

Part III FEE ARRANGEMENT

☒ **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.) (Select an option, sign and date this section.)*

☐ **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.)*

☐ **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, 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.)*

☐ **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 Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

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

INDIVIDUAL authorizing disclosure

SIGN ▶

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:*

SIGN ▶

Phone Number (or Address)

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

SIGN ▶

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.

Only Complete for New claims.
NOT appeals

Social Security disability application intake form

1.name

2. address

3. phone number

4.Social Security number

5date of birth

6.Place of birth (town and state)

7. marital status

8.date and location of marriage

9.spouse's name

10. previous disability applications

11highest grade in school

12. date last worked

13. work history, past 15 years (including employers names)

14. Dr. who supports disability claim incl phone number and address

15. list of disabilities

16. list of medications

17 height and weight

18 Date Disability began

19 citizen status

20 military service

21workers compensation involved?

22 any outstanding felony warrants?