DEPARTMENT OF HUMAN RESOURCES (DHR)
DISABILITY ENTITLEMENT ADVOCACY PROGRAM (DEAP)

Consent for Release of Information

LDSS District Office ____

Sign this form only if you want the Social Security Administration to give information or records about you to DEAP.

TO: Social Security Administration

Customer's Name____

Date of Birth______________ Social Security Number__________________________

THIS SECTION TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION

____No Record ____Supplemental Security Income ____Social Security Disability Income

____Terminated Record __________ SSI Date Terminated _____________
MMDDYY

Current Claim Status

____ SSI Claim Pending:		**____ SSDI Claim Pending:**	
Initial Claim	Date Filed ________	Initial Claim	Date Filed ________
Reconsideration	Date Filed ________	Reconsideration	Date Filed ________
Hearing Level	Date Filed ________	Hearing Level	Date Filed ________
____ SSI Claim Denied:		**____ SSDI Claim Denied:**	
Initial Claim	Date Denied ________	Initial Claim	Date Denied ________
Reconsideration	Date Denied ________	Reconsideration	Date Denied ________
Hearing Level	Date Denied ________	Hearing Level	Date Denied ________

(Circle One)

Denial Reason: Medical Non-Medical Other | **Denial Reason: Medical Non-Medical Other**

Interim Assistance Reimbursement: (Check one)

_____Not posted to SSA record

_____Posted to the record and pending

_____Paid

Allowance

____ SSI: Eligibility date __________ **_____ SSDI: Eligibility date ____________**

ATTACHMENT B (Side 2)

LDSS District Office ____

Customer's Name ____

Date of Birth ______________ Social Security Number ________________________

I authorize SSA to release the dates and status of my Social Security Disability Insurance and/or Supplemental Security Income application(s), along with the status of the Interim Assistance Reimbursement for my claim to:

DEAP
1 North Charles Street, Suite 1300
Baltimore, Maryland 21201
Fax# 410-332-1665

This consent for release of information is in effect from __________ to __________ (not to exceed 1 year).
(MMDDYY) (MMDDYY)

I want this information released because I am pursuing entitlement to Social Security programs.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information that I provided on this form and that it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: ____________________________________ Relationship: ____________________

(Below, show signatures, names, and addresses of two people if signed by mark.)

Date: __________________

Witness #1

____
(Print Name)

____
(Signature)

____
(Address)

____
(City, State, and Zip code)

Witness #2

____
(Print Name)

____
(Signature)

____
(Address)

____
(City. State, and Zip code)

SSA Claims information was provided by: ____
(SSA Liaison)

Date Request Received: _______________ **Date of Response** ___________________

Telephone Number: _____________

SSA Field Office Code: __________