



Department of Human Resources
311 West Saratoga Street
Baltimore MD 21201

FIA ACTION TRANSMITTAL

Control Number: #99-46 - ATTACHMENTS

Effective Date: July 1, 1999

Issuance Date: July 7, 1999

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS
ASSISTANT DIRECTORS OF ADMINISTRATION/ FINANCE
OFFICERS, LOCAL DEPARTMENTS OF SOCIAL SERVICES

FROM: 
ROBERT J. EVERHARD, EXECUTIVE DIRECTOR

RE: DEAP/TCA PROGRAM (AT #99-46) - ATTACHMENTS

PROGRAM AFFECTED: TEMPORARY CASH ASSISTANCE

ORIGINATING OFFICE: OFFICE OF POLICY, RESEARCH AND SYSTEMS

SUMMARY

Action Transmittal (AT) FIA/OPRS #99-46 provided a Guide to policy and procedures for the state-funded TCA program for disabled TCA customers who are referred to the Disability Entitlement Advocacy Program (DEAP/TCA). Page 10 of the Guide listed the forms used for the DEAP/TCA program. The nine attachments (copies of the forms) were inadvertently omitted from the Guide. This AT provides those attachments.

ACTION DUE:

These forms are used for TCA applications filed and the first TCA redetermination or interim change (when reporting a disability) on or after July 1, 1999.

INQUIRES:

Please direct policy questions to Edna McAbier at 410.767.8805 or Steve Sturgill at 410.767.7733, Bureau of Policy and Training.

c: DHR Executive Staff
FIA Management Staff
Constituent Services
OIM Help Desk
CTF

STATE OF MARYLAND
DEPARTMENT OF HUMAN RESOURCES
LOCAL DEPARTMENT OF SOCIAL SERVICES

PURCHASE AUTHORIZATION AND INVOICE
(Prepare in Duplicate: Original to Vendor; Duplicate to Finance Officer)

VENDOR: (Name and Address-Print or Type)	CASE INFORMATION:
	Name: _____
	Case Number: _____
	Category: _____
AUTHORIZATION SIGNATURES:	
Worker: _____	
Supervisor: _____	

SERVICES OR MATERIALS AUTHORIZED:	COST NOT EXCEED:
	\$ _____

	Attendance during month of full-time on-campus school program in child care facility.
	Burial
	Day Care
	Initial Clothing
	Group Home
	Eye Examination (Report of Eye Examination, form DHR/SSA 701 must accompany invoice; payment made after State Review). Review in hand.
	Medical Examination (Medical Examination Record, Form 402, must accompany invoice; payment after State Review). Payment will <u>not</u> be authorized for an incomplete form.
	Other (Specify)

INVOICE: (Do Not Detach)

LOCAL DEPARTMENT OF SOCIAL SERVICES:	VENDOR: (Print or Type)
SERVICES OR MATERIALS FURNISHED:	AMOUNT: \$ _____
	TOTAL: \$ _____

VENDOR SIGNATURE: _____ DATE: _____

VENDOR FEDERAL ID OR SOCIAL SECURITY NUMBER: _____

MARYLAND DEPARTMENT OF HUMAN RESOURCES
DEPARTMENT OF SOCIAL SERVICES

INTERIM PAYMENT REIMBURSEMENT AUTHORIZATION

Customer ID Number _____	AU Number _____	Category _____	Social Security Number _____
District/Territory _____	Federal Code _____	County DSS Federal Code _____	
Applicant's Name _____		Address _____	
<small>(Last)</small>	<small>(First)</small>	<small>(Middle)</small>	
City or Town _____		Zip Code _____	- Telephone _____

By signing this form and checking the appropriate block below, I authorize the Commissioner of the Social Security Administration (SSA) to send my Supplemental Security Income (SSI) benefits to the Maryland Department of Human Resources (DHR).

I also authorize DHR to deduct from my initial payment, as described in the block below, an amount equal to the sum of all welfare state-funded public assistance benefits (not including assistance payments financed wholly or partly with Federal funds) made to me on behalf of me by the Maryland DHR:

Initial Eligibility beginning with first month I am found eligible to receive an SSI payment and ending with the month my SSI payments begin.

or

Post Eligibility beginning with the day my SSI benefits are reinstated after a period of suspension or termination and ending with (and including) the month my SSI payments resume.

I understand that, after making the deductions described above from my first payment, Maryland DHR shall pay me the balance, if any, no later than ten (10) working days from the date the Maryland DHR receives my payment from SSA, unless the Social Security Act requires SSA to pay such balance. In such an event, SSA will notify me of the manner in which the balance, if any, will be paid to me.

I understand that I have the right to a fair hearing before the Office of Administrative Hearings (OAH) if I feel that the amount deducted from my SSI payment is more than the amount of public assistance benefits paid to, or on behalf of, me by Maryland DHR.

I understand this authorization must be signed by me and a DHR representative and that it is effective from the date the Maryland DHR receives it and that it will cease to have effect:

Initial Eligibility at the end of one (1) year from the date I signed the authorization, if it occurs earlier, in which case the authorization will cease to have effect as of the date of such event:

- SSA makes an initial payment on my claim;
- SSA makes a final determination on my claim and no timely request for review is filed by me; or Maryland DHR and I agree to terminate the authorization.

or

Post Eligibility at the end of one (1) year from the date I signed the authorization, or at the end of the maximum period permitted under 20 CFR (Code of Federal Regulations), Subpart N, within which to request a review of the determination by the SSA to suspend or terminate my SSI benefits, whichever period of time is longer, unless I file a timely request for such an event:

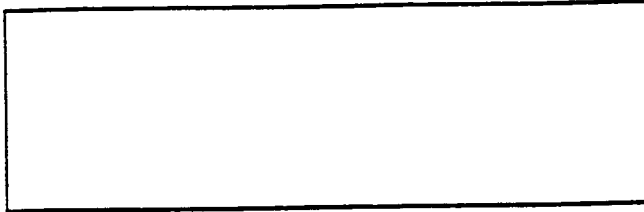
- SSA releases payment on my claim or record which has been reinstated to payment after a period of suspension or termination; or
- SSA makes a final determination on my claim and I do not file a timely request for review; or Maryland DHR and I agree to terminate the authorization.

I understand that signing this form in an initial claim situation means:

- I want to file for SSI payments.
- I must file for SSI with a Social Security Administration (SSA) office and that SSA will decide if I am eligible for SSI.
- My eligibility for SSI can begin as early as the date I sign this form only if I file for SSI within 60 days of the date I sign this form.

Customer's Signature	Telephone Number	Date
Local Department Representative's Name/Title	Telephone Number	Date

Department of Social Services
MEDICAL REPORT



District: _____
Worker: _____
Phone #: _____
Date: _____
Client ID: _____
Pharmacy Assistance: NONE
 Active Case Application Taken

The information provided on this form may be used to determine eligibility for federal and state programs using Social Security disability criteria.

Part I: (To be completed by client)

Name: _____ Birth Date: ___/___/___ Last Grade Completed: _____
Address: _____ Telephone #: _____

1. What illness or injury keeps you from working? _____
Were you injured on the job? Yes No
2. What other health problems do you have? _____

I authorize the physician/health practitioner to release any information about my medical condition required by the state to determine eligibility for benefits.

Client's Signature: _____ Date: _____

Part II: (To be completed by Examining Physician/Health Practitioner)

Date of Examination: _____ First Visit: _____ Last Visit: _____

Please provide detailed responses regarding the patient's impairment(s), based on the most recent examination or treatment record. Copies of laboratory reports, x-ray reports, EKG tracings, and other studies that support a finding of disability should accompany this report. Please continue responses on a separate sheet, if needed, attaching it securely to this form.

1. DIAGNOSIS: Please state the major or chief physical and/or mental impairment(s), that may result in the inability to perform work, activity, or routine activity of daily living.
- | | | |
|-------|----------------|-------------------------------|
| _____ | ICD-9-CM _____ | Estimated Date of ONSET _____ |
| _____ | ICD-9-CM _____ | _____ |
| _____ | ICD-9-CM _____ | _____ |
| _____ | ICD-9-CM _____ | _____ |

Is a substance addiction disorder indicated? Yes No

2. HISTORY OF IMPAIRMENT(S): Include at a minimum: a) description of the pertinent history of the impairment; b) treatment and hospitalization, including a description of those factors that limit the patient's ability to function. Include all current medications by drug name and dosage.

MEDICAL REPORT

3. REVIEW OF SYSTEMS: Present all pertinent findings in making a differential diagnosis or evaluating the severity of the impairment, including a family history, and a description of the use of alcohol, tobacco, or any non-prescription medication.

4. PHYSICAL FINDINGS: Include your observations and significant findings related to the impairment(s). This must include all information as requested, and a description of the patient's general appearance and behavior during the examination. Present specific findings objectively, for example, range of motion of a joint, should be reported in degrees.

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Respiration: _____
Muscle Strength (1/5 to 5/5): UE _____ LE _____

5. MENTAL FINDINGS: Include/attach psychiatric and psychological evaluations. Results of well-standardized psychological tests (e.g., WAIS).

6. LABORATORY/XRAY/TEST RESULTS: Include the actual values for laboratory tests, xray reports, electrocardiograph and or spirometric tracings. Indicate CD4 count, and viral load result.

7. TREATMENT AND RESPONSE: Include past treatment and response, if known; projected treatment and anticipated response, include all medication and/or recommended therapy.

8. HIV/AIDS- INFECTION: Opportunistic and Indicator Diseases (Please check if applicable)
 Bacterial Infections HIV Wasting Syndrome Viral Infections Diarrhea Malignant Neoplasms
 Protozoan or Helminthic Infections Neurological Abnormalities Fungal Infections
 Other, specify: _____

Based upon your evaluation is this patient impaired? Yes No If yes, duration from _____ to _____
Is the patient able to work? Yes No

TO THE PHYSICIAN/HEALTH CARE PRACTITIONER COMPLETING THIS FORM:

My signature indicates that this information is correct to the best of my knowledge. I understand that if this form is not completed in its entirety, it will be returned to me by the local department and I will not be reimbursed.

Name: _____

Address: _____

Telephone: _____

Printed Name: _____

Title: _____

License #: _____

MA Provider # _____

Date: _____



TCA SUPPLEMENTAL MEDICAL EVALUATION FORM -- ADULT ONLY

(TO BE COMPLETED BY THE DISABLED ADULT OR REPRESENTATIVE)

1. NAME: _____ 2. DOB: _____

2. Were you ever not able to work because of a physical illness? YES NO

If yes, please explain: _____

3. Were you ever not able to work because of a mental illness? YES NO

If yes, please explain: _____

4. Are you under the care of a doctor now? YES NO

Doctor's Name: _____ Last Appointment: _____

Address: _____ Next Appointment: _____

5. Are you taking any medicine now? YES NO

Do you take your medicine as your doctor says you should? YES NO

If NO, why not: _____

6. List the names of and the time taken of all your medications (prescription or not):

Name	Time	Name	Time
_____	_____	_____	_____
_____	_____	_____	_____

7. Have you been in the hospital in the last twelve months? YES NO

Hospital Name: _____ Date: _____

Your illness: _____

8. Are you now or have you ever been in an addiction program? YES NO

If yes, Alcohol Drugs Date: _____

Program's name and address: _____

9. Have you ever tested positive for HIV/AIDS? YES NO

10. Are you able to do regular daily activities? YES NO
 If NO, with which activity do you need help?
- Dressing Personal hygiene Preparing meals Household chores

11. What are your hobbies or other activities?

12. Is it hard for you to remember things and follow instructions? YES NO
13. Are you able to read and write? YES NO
14. Are you able to understand and follow directions? YES NO
15. Have you ever been told that you have a learning disability? YES NO

If YES, who told you _____ When _____

16. Do you have a high school diploma or a GED? YES NO

17. When did you last work? Date: _____ Place: _____

Job title and kind of work: _____

18. Are you able to do that type of work now? YES NO

19. What kind of work do you feel you are able to do now?

20. What help do you need to get a job and become independent?

21. Do you have difficulty with any of these activities listed? If YES, check how difficult.

Walking	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Minimum	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Standing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Minimum	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Lifting	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Minimum	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Bending	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Minimum	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Climbing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Minimum	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme

22. Do you use a cane, wheel chair, or other means of help? YES NO

If YES, what kind? _____

23. Please list all doctors, clinics and hospitals that have treated you in the past or are treating you now:

Name:

Address:

Reason treated:

Medication: Date last seen:

Name:

Address:

Reason treated:

Medication: Date last seen:

Name:

Address:

Reason treated:

Medication: Date last seen:

Name:

Address:

Reason treated:

Medication: Date last seen:

Name:

Address:

Reason treated:

Medication: Date last seen:

24. Please explain how your illness keeps you from working:

25. Please check any of the programs and services that you are now getting or attending:

- Mental health Counseling Drug Alcohol
- Parole and Probation Family Services Child Protective Services
- Other: _____

26. Have you ever applied for disability benefits? YES NO
If YES, check all that apply:

- SSI Dates: _____ Denial date: _____
- SSDI Dates: _____ Denial date: _____
- Workers' Compensation Dates: _____ Denial date: _____
- Insurance Settlement Company name: _____ Claim date: _____
- Accident Settlement Company name: _____ Claim date: _____
- Other, please list: _____

27. Please tell us any other information about you that you feel we need to know:

Customer's Signature: _____ Date: _____

Case Manager's Signature: _____ Date: _____



TCA SUPPLEMENTAL MEDICAL EVALUATION FORM – CHILD ONLY

(TO BE COMPLETED BY THE CHILD'S PARENT/CARETAKER RELATIVE)

1. Child's Name: _____ 2. DOB: _____

3. Child's Disability: _____

4. Is your child under the care of a doctor? YES NO

Doctor's Name: _____

Address: _____

5. Time spent each day helping your child: _____

6. Check the activities that your child can do without help:

- Dressing
- Eating
- Bathing
- Moving freely in the home
- Running
- Walking
- Playing
- Using the bathroom
- Watching television
- Playing video games
- Other: _____

7. List the activities that your child cannot do without help:

8. Does your child attend school, Head Start, or day care? YES NO
If YES, check one (or more) of the following:

- Public/private school in grade _____ Head Start Day Care
- Special Education Intensity level: * _____ Other: _____

Number of days each week: _____ Number of hours per day _____

9. Tell us why you feel you are needed in the home to care for your child: _____

• If level IV or greater, refer to DEAP.

Customer's Signature: _____ Date: _____

Case Manager's Signature: _____ Date: _____

Social Security Administration

Form Approved

Please read the back of the last copy before you complete this form.

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 IV FMSHA (Black Lung)
 Title XVIII (Medicare Coverage)

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 am appointing, or I now have, more than one representative. My main representative is _____
(Name of Principal Representative)

Signature (Claimant)	Address
Telephone 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.)

I am an attorney.
 I am not an attorney.
 (Check one.)

Signature (Representative)	Address
Telephone 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
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Part IV (Optional) ATTORNEY'S WAIVER OF DIRECT PAYMENT

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung 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 (Attorney Representative)	Date
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COMPLETING THIS FORM TO APPOINT A REPRESENTATIVE

Choosing To Be Represented

You can choose to have a representative help you when you do business with Social Security. We will work with your representative, just as we would with you. It is important that you select a qualified person because, once appointed, your representative may act for you in most Social Security matters. We give more information, and examples of what a representative may do, on the back of the "Claimant's Copy" of this form.

Paperwork and Privacy Act Notice

The Social Security Administration will recognize someone else as your representative if you sign a written notice appointing that person and, if he or she is not an attorney, that person signs the notice agreeing to be your representative. (You can read more about this in our regulations: 20 CFR §§ 404.1707, 410.684, and 416.1507.) Giving the information this form requests is voluntary. Without it though, we may not work with the person you choose to represent you.

How To Complete This Form

Please print or type. At the top, show your full name and your Social Security number. If your claim is based on another person's work and earnings, also show the "wage earner's" name and Social Security number. If you appoint more than one person, you may want to complete a form for each of them.

Part I Appointment of Representative

Give the name and address of the person(s) you are appointing. You may appoint an attorney or any other qualified person to represent you. You also may appoint more than one person, but see "What Your Representative(s) May Charge" on the back of the "Claimant's Copy" of this form. You can appoint one or more persons in a firm, corporation, or other organization as your representative(s), but you may not appoint a law firm, legal aid group, corporation, or organization itself.

Check the block(s) showing the program(s) under which you have a claim. You may check more than one block. Check:

- Title II (RSDI), if your claim concerns retirement, survivors, or disability insurance benefits.
- Title XVI (SSI), if your claim concerns supplemental security income.
- Title IV FMSHA (Black Lung), if your claim concerns black lung benefits under the Federal Mine Safety and Health Act.
- Title XVIII (Medicare Coverage), if your claim concerns entitlement to Medicare or enrollment in the Supplementary Medical Insurance (SMI) plan.

If you will have more than one representative, check the block and give the name of the person you want to be the main representative.

How To Complete This Form, continued

Sign your name; but print or type your address, your area code and telephone number, and the date.

Part II Acceptance of Appointment

Each person you appoint (named in part I) completes this part, preferably in all cases. If the person is not an attorney, he or she must give his or her name, state that he or she accepts the appointment, and sign the form.

Part III (Optional) Waiver of Fee

Your representative may complete this part if he or she will not charge any fee for the services provided in this claim. If you appoint a second representative or co-counsel who also will not charge a fee, he or she also should sign this part or give us a separate, written waiver statement.

Part IV (Optional) Attorney's Waiver of Direct Payment

Your representative may complete this part if he or she is an attorney who does not want direct payment of all or part of the approved fee from past-due retirement, survivors, disability insurance, or black lung benefits withheld.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

Time It Takes to Complete This Form

We estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Building, Baltimore, MD 21235. Send only comments relating to our "time it takes" estimate to the office listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.

References

- 18 U.S.C §§ 203, 205, and 207; 30 U.S.C. § 923(b); and 42 U.S.C. §§ 406(a), 1320a-6, and 1383(d)(2)
- 20 CFR §§ 404.1700 et. seq., 410.684 et. seq., and 416.1500 et. seq.
- Social Security Rulings 88-10c (C.E. 1988), 85-3 (C.E. 1985), 83-27 (C.E. 1983), and 82-39 (C.E. 1982)

TCA ADULT

Social Security Administration

Form Approved

Please read the back of the last copy before you complete this form.

OMB No. 0960-0527

Name (Claimant) (Print or Type) CUSTOMER'S NAME	Social Security Number CUSTOMER'S SSN
Wage Earner (If Different)	Social Security Number

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, DEAP (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 IV FMSHA (Black Lung)
- Title XVIII (Medicare Coverage)

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 am appointing, or I now have, more than one representative. My main representative is _____ (Name of Principal Representative)

Signature (Claimant) CUSTOMER'S NAME	Address CUSTOMER'S ADDRESS
Telephone Number (with Area Code) () CUSTOMER/CONTACT NUMBER	Date DATE SIGNED

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.)

I am an attorney. I am not an attorney. (Check one.)

Signature (Representative)	Address
Telephone 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
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Part IV (Optional) ATTORNEY'S WAIVER OF DIRECT PAYMENT

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung 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 (Attorney Representative)	Date
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TCA CHILD

Social Security Administration

Form Approved

Please read the back of the last copy before you complete this form.

OMB No. 0960-0527

Name (Claimant) (Print or Type) PARENT/GUARDIAN NAME * 0/6/0 CHILD	Social Security Number CHILD'S SSN
Wage Earner (If Different)	Social Security Number

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, DEAP (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 IV FMSHA (Black Lung)
- Title XVIII (Medicare Coverage)

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 am appointing, or I now have, more than one representative. My main representative is (Name of Principal Representative)

Signature (Claimant) PARENT/GUARDIAN NAME 0/6/0 CHILD	Address PARENT/GUARDIAN ADDRESS
Telephone Number (with Area Code) () PARENT/GUARDIAN NUMBER	Date DATE SIGNED

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.)

I am an attorney. I am not an attorney. (Check one.)

Signature (Representative)	Address
Telephone 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) ATTORNEY'S WAIVER OF DIRECT PAYMENT

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or black lung 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 (Attorney Representative)	Date
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* ON BEHALF OF

DISABILITY
ENTITLEMENT
ADVOCACY
PROGRAM

301 N. Charles Street, Suite 100
Baltimore, Maryland 21201
(410) 332-0185
1-800-727-6454
FAX: (410) 332-1665

MEMORANDUM

To: *Local Department of Social Services Name*

Date:

Subject: Withdrawal of Representation

Name: *Customer Name*

Case#:

SSN:

DEAP has closed the above-named customer's case for the reason stated below:

MENU CHOICES

- The client moved out of Maryland
- The client intends to or has returned to work or school
- The client's disability is not severe enough to pursue the claim
- The client has not responded to attempts to contact him/her
- The client has requested that we close his/her case
- The client is incarcerated
- The client is technically ineligible for SSI
- The client refused to cooperate with DEAP or Social Security
- The client withdrew his/her SSI application
- The client is an ineligible alien

We are withdrawing our representation with Social Security. We have notified the customer.

HMA/DEAP M3038