Social Security Disability

Edlyn L. Willer

The Legal Aid Society

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THE SOCIAL SECURITY PROGRAMS

Any person may apply for social security disability benefits, but to receive such benefits, this person has to fit within specific boxes as set forth by the social security regulations noted herein.


Title II or SS benefits: 42 USCS §§401-433 and Title XVI or SSI benefits 42 USCS §§1381-1383d.

Code of Federal Regulations

Title II 20 CFR part 404

Medical Guidelines (“Listings”): Subpart P, Section 1
Vocational Guidelines (“Grid”): Subpart P, Section 2

Title XVI: 20 CFR Part 416.

Social Security Rulings and Acquiescence Rulings:

According to the social security regulations, these rulings may be based on case decisions made at all administrative levels of adjudication, Federal court decisions, Commissioner’s decisions, opinions of the Office of the General Counsel, and other policy interpretations of the law and regulations. Social Security Rulings are first published in the Federal Register. Social Security Rulings are effective upon publication, and the effective date is shown on the first page of each Ruling. Although Social Security Rulings do not have the force and effect of the law or regulations, they are binding on all components of the Social Security Administration (SSA) in accordance with section 402.35(b)(1) of the Social Security Administration Regulations (20 CFR Part 402), and are to be relied upon as precedents in adjudicating other cases. See www.ssa.gov.

Acquiescence Rulings or AR:

Reflects the court opinions that are inconsistent with the Social Security Policy or interpretation but may still be followed within a particular circuit or issuance. The Acquiescence Rulings explain how the Social Security Administration (SSA) will apply decisions of the United States Courts of Appeals that are at variance with SSA’s national policies in adjudicating claims under title II and title XVI of the Social Security Act and Part B of the Black Lung Benefits Act. Acquiescence Rulings do not have the force and effect of the law or regulations, however, they are binding on all components of SSA in accordance with section 402.35 (b)(2) of the Social Security Administration Regulations (20 CFR Part 402). Citation often include a reference to the Ruling number and either
the date it was published on a flow basis or to the *Cumulative Edition* in which it appears. For example, Social Security Ruling number twenty-three published on September 18, 1987, should be cited as SSR 87-23 (9/18/87), or as SSR 87-23 (C.E. 1987); or Social Security Rulings based on court decisions are identified by the suffix “c” (such as SSR 80-1c), and Social Security Rulings based on decisions of the Appeals Council of the Office of Disability Adjudication and Review are identified by the suffix “a” (such as SSR 80-1a). Policy Interpretation Rulings are identified by the suffix “p” (such as SSR 89-5p).

**Circuit Court Decisions:** CFR §416.1485, sets forth the particular determination as to the application of circuit court law.

**POMS: Program Operation Manual Systems:** arranged by General subject area, followed by the Chapter which covers a topic. The POMS is the manual of substantive and procedural materials that are used by offices of the Social Security Administration (except Office of Hearings and Appeals or Appeals Council).

**HALLEX [Hearings & Appeals Litigation and Law Manual]**

Manual of procedural and substantive material for the Office of Hearings and Appeals (OHA). According to the social security determination, through HALLEX, the Deputy Commissioner for Disability Adjudication and Review conveys guiding principles, procedural guidance, and information to Office of Disability Adjudication and Review staff. HALLEX defines procedures for carrying out policy and provides guidance for processing and adjudicating claims at the hearing, Appeals Council, and civil action levels. It also includes policy statements resulting from Appeals Council *en banc* meetings under the authority of the Appeals Council Chair.

**Other Materials:**

**Barbara Samuels Social Security Disability Claims manuals:** Social Security Disability Claims: Practice & Procedure, 2d, Copyright: 2003-2015. This is a fully rounded manual which sets forth the general social security regulations and guidance for anyone interested in developing a general knowledge of the practical guide to learning the basics of social security disability law.
ADMINISTRATIVE PROCEDURES

APPLICATION TO APPEAL. 20 C.F.R. Pt.404 Sbpt.J,Q; Pt.416, Sbpt. J, N.

1. Generally, written application must be filed at Social Security Office on prescribed form. Certain specified exceptions. Applicants can also call Social Security’s toll free number (800/772-1213) to apply. They will be given an appointment to go to the office to submit documentation. However, the date of their call is the protective filing date.
   a. Filing of Title II application can be considered protective filing for SSI. 20 C.F.R. § 416.350.

2. SSA contracts with N.Y.S.Office of Temporary and Disability Assistance (“OTDA”, formerly “DSS”). Division of Disability Determinations to make initial determination.
   a. DDD examiners.
   b. Consultative physicians/examiners.
   c. Medical review physicians. (RFC’s)

3. Claimant receives notice of initial determination with appeal rights.

4. In most of the country (except for 8 states, parts of California, and New York) claimant has 60 days to request reconsideration at SSA office in writing. Reconsideration is still part of appeal process for determinations of issues other than disability. If individual has right to reconsideration to appeal adverse decision on overpayment or other issues, must be requested in 60 days.

5. Claimant has 60 days to request hearing in writing at SSA office.

6. Hearing held at Office of Disability Adjudication and Review (ODAR) before Administrative Law Judge. [Currently, there are major delays ranging from 12-19 months].

7. Claimant has 60 days from receipt of hearing decision to request review by the Appeals Council of OHA/SSA. (Step may be eliminated in pilot project areas.)

8. Appeals Council may also do own motion review.

NOTES
GENERAL PRO BONO PROGRAM

For many years, the Legal Aid Society, has set forth an effective program which enables local law firms to work with attorneys at the Legal Aid Society during the representation of a case before the Social Security Administration. At the outset, the Legal Aid Society provides training as well as written reference materials for the attorneys at the law firms who may have an interest in working with an attorney at Legal Aid to represent a claimant at a social security hearing.

The referral will generally include a brief overview of the case and the likely issues involved. The Pro Bono Coordinator then submits the summary to the available firms and a review is done on both sides to make sure that there are no prior contacts which may cause conflicting issues between the parties and or law firm. Once all of the major issues are worked through, a meeting is scheduled with client, the pro bono attorney and the Legal Aid Society, at the local Legal Aid office.

First Meeting

The Legal Aid attorney generally goes through the process and the general expectations and explains the program and expectations from the client’s perspective as well as from that of the attorney for the client. General issues for pro bono attorney and client, include a general partnership for all involved. Thus, the client and the pro bono attorney are expected to sit and try to “meet” at this first meeting.

At this first meeting, it is important to set forth explanations which deals with several matters including:

- Agreement for the work to be done by the pro bono attorney;
- General follow-ups, including office meetings and preparation for upcoming hearing;
- Follow-up with client’s medical team, including getting summary statements or additional medical forms from doctors, nurses or other medical and non-medical sources in preparation for the hearing.

Subsequent Meetings

As the parties become acquainted, they would continue to develop the case with additional meetings as well as ongoing telephone conversations. At some point, the attorney from Legal Aid would step in to make sure that everyone is on the same page. It may also become necessary to obtain additional medical information and this may be a
collaborative effort between the pro bono attorney and the Legal Aid attorney and sometimes the client. The bottom line is that there is a great deal of emphasis on getting things squared away so that when the hearing comes around, everyone has the information to provide to the ALJ so that the claimant may prevail.

Based on the experience level of the pro bono attorney, I may provide the attorney with sample client write-ups, which are general outlines of the case and the possible medical diagnosis provided for disability. This may include a sample memo which the attorney may use to summarize the client’s medical issues and the type of case we assert that makes this person disabled. During the course of the representation, I would have conversations with the attorney and provide them with sample forms to get additional medical information from the doctors. This relationship continues for the duration of the representation.

Following the ALJ presentation, there is just the wait for the hearing decision. Sometimes the clients would return to my office with follow-up questions. Once the decision comes in, I generally send a letter to the client explaining the process, whether they can appeal or if they prefer to reapply if there is a loss; or what to expect if there is a win.

• Attached is a blank form SSA-1696 Appointment of Representative form, which is submitted once a representative becomes involved to appear at the social security hearing.

• Additional forms attached include sample HIPAA forms to obtain additional medical records.

• For continuation of the presentation, you will also hear from one of the attorneys who had this role in a past case with the Legal Aid Society: Anne Elise Herold Li, Counsel; ali@crowell.com. Crowell & Moring LLP, 590 Madison Avenue, 20th Floor, New York, NY 10022.
THE ADMINISTRATION HEARING PROCESS
20 C.F.R. § 404.929 et seq.; § 416.1429 et seq.

A. The Hearing

1. Notice 20 days prior to hearing.
   a. Sets forth issues to be decided.

2. ALJ must be impartial fact finder.

3. Standards of conduct for claimants’ representatives.
   a. Code of Professional Responsibility
   b. SSA regulations 20 CFR §404.1740, §416.1540.
      Sets forth rules of conduct and standards of responsibility for representatives, such as attorney’s fiduciary duty to client, acting with reasonable promptness to obtain information, assist the claimant in complying, etc.

4. Hearing is non-adversarial administrative hearing.
   b. ALJ has discretion in conduct of hearing, but must allow claimant opportunity to present case, and effective assistance of counsel, if represented. Setting is small, private hearing room.

5. Hearing record is made. Protect it.

6. ALJ may call expert witnesses as consultants. Hallex § I-2-5-30
   a. Medical Advisors. Hallex § I-2-5-32
   b. Vocational Experts. Hallex § I-2-48

7. Opportunity to make objections, offer new evidence for record at beginning of hearing.
   a. If record is incomplete, request that it remain open to submit additional evidence within certain period of time.
   b. If necessary, request time to submit post-hearing memorandum or closing statement.

8. Elements of the Hearing.
   a. ALJ usually gives opening statement describing issues and legal standard.
b. Representative can make opening statement describing the theory of the case or can, instead submit a written pre-hearing statement before the hearing date.

c. Witness (usually claimant is primary witness, but there may be others) takes an oath.

d. Testimony is taken: Most ALJs prefer to ask all their questions first. Medical expert and vocational expert testimony (if any) is generally taken after the claimant testifies.

B. Preparing for the Hearing.

1. Evidentiary Development of Claims

a. THE BURDEN OF PROOF

The Burden is on the claimant to produce medical evidence that s/he is unable to work by reason of a medically determinable impairment or combination of impairments. 20 C.F.R. §§404.1512; 416.912

The most important thing a representative does to assist a claimant with a disability case is obtain medical evidence. Although the local social security office may take some steps to assist the claimant with this, it is minimal.

Never assume your client will be found to meet or equal a Listing at Step 3. Always plan to prove case at each step of the Sequential Evaluation.

If you do not think the GRIDS should apply, be prepared to show that claimant’s non-exertional impairments significantly reduce his/her RFC and be prepared to cross-examine a vocational expert.

b. DOCUMENTATION: Be prepared to document everything, including, but not limited to:

(a) Physical or mental impairment(s);

(b) Pain, shortness of breath, anxiety, nervousness, dizziness, fatigue, weakness or other subjective complaints including duration, intensity, persistence and response to medication/treatment;

(c) Date of onset;

(d) Level of education, ability to communicate in English, literacy;
(e) Age;
(f) Work history/vocational skills;
(g) Activities of daily living (which may show ability to perform work-related tasks).

c. **WHERE TO OBTAIN EVIDENCE**

(a) Medical Evidence: 20 C.F.R. §§404.1513; 416.913

- **Physical**: treating physician and reports and records; hospital records (inpatient, clinic, emergency, office); clinic notes, laboratory findings, diagnostic tests, therapy notes, chiropractic, medical assessments or consultations, consultative examinations (CE’s).
  - **Mental**: treating psychiatrist, Ph.D. or CSW, progress notes or reports; psychological evaluations and testing; in-patient psychiatric hospitalizations; opinions and medical assessments, consultative examinations (CE’s).

(b) Vocational Evidence

- Past employers; co-workers; supervisors; vocational rehabilitation programs (e.g., VESID); psychological evaluations and test results; the Dictionary of Occupational Titles (DOT).

c. Educational/Behavioral Evidence (children’s cases)

- Pediatrician and other pediatric specialists; past and current teachers; counselors; principals; school records, Individual Education Profiles (called IEP’s); babysitters; siblings and other relatives.

(d. **Weight of Evidence**: 20 C.F.R. §§404.1527(d); 416.927(d).

Generally, evidence from the claimant’s treating physician is given more weight than that from other sources. If the treating source’s opinion as to the nature and severity of the claimant’s impairment is well supported by medically acceptable clinic and laboratory diagnostic techniques, and is not inconsistent with other substantial evidence of record, it will be given controlling weight. SSA will consider the length of doctor/patient relationship; whether the report indicates what was reviewed when making the stated findings; and the specialization of the physician.
C. **Interviewing the Client**

1. **Procedural History.**
   - How many times has claimant applied?
   - Reopening necessary?

2. **Non-disability Issues.**
   - Financial or earnings record eligibility.
   - Benefit to client of proceeding with Title XVI claim.

3. **Medical History.**
   - Illnesses, injuries, hospitalizations, every place treatment is received.
     (1) Dates of treatment
     (2) Treating physicians/hospitals.
     (3) Medications/therapies.
     (4) Symptoms, subjective complaints.

4. **Daily activities.**
   (1) Ability to function physically & mentally
   (2) Is assistance provided by family, friends or paid caregivers?
   (3) How are chores performed, who cooks, shops, cleans?
   (4) How does client get to medical appointments?

5. **Obtain medical releases.**
   - Obtain medical releases so you can get additional medical evidence, and have client sign Appointment of Representative form with fee waiver.

6. **Reviewing the Case Record.**
   - Get a copy of the Exhibit File from the hearing office (Office of Disability Adjudication and Review). Be sure to have client sign an authorization to obtain the Exhibit File.
     a. **Hearing Record**
        - Application, Disability Questionnaires, Vocational Histories, Agency transmittals, notices, requests for reconsideration, request for hearing and hearing notices.
        - Medical reports, consultative evaluations, RFCs by review physicians, psychiatric assessments (listings), hospital records.
Earnings record.
Prior decisions, Appeal Council remands.
Qualifications of expert witnesses.

7. Developing the Medical Evidence.
   a. Contact treating sources.
      
      (1) Use evaluation forms to update the medical evidence. Has claimant’s condition gotten worse since application?

      (2) Call the claimant’s treating physician(s) and request a letter or report containing the relevant information (history, treatment relationship, diagnoses, reported symptoms, medical findings, consistency of symptoms with medical findings, treatment provided, results and side-effects, if any; compliance with treatment, prognosis, medical assessment (RFC). Offer to assist MD in writing/typing a draft of the letter or report for signature.

      NOTE: If the physician is reluctant to provide the information you need to prove disability, acknowledge that the physician may not be familiar with Social Security’s requirements for disability benefits. Be prepared to discuss and explain the following factors which should be considered:

      Disability standards utilized by SSA. Explain the requirements and how your client meets the criteria.

      RFC Assessments. Point out that SSA considers RFC assessments to be medical opinions. Ask the physician to discuss functional limitations with the patient and report results which make sense to the physician.

      Substantial Gainful Activity (“SGA”). Remind the physician that a claimant who is not disabled must be able to engage in full time, competitive employment seven or eight hours a day, five days a week on a permanent basis.

      Travel required to get to work. Ask the physician to consider the fact that in order to perform SGA, the patient must be able to travel by bus or subway to and from work twice a day, five days a week during rush hour, regardless of weather conditions.
Special conditions for rest or movement. Remind the physician that very few jobs permit an individual to lie down if s/he feels ill or to move around at will if this is necessary to avoid pain or stiffness.

Pain and other symptoms. Point out that a claimant can be found disabled based on subjective symptoms as long as these symptoms are attributable to a medically determinable physical or psychiatric impairment.

Alternative medical or psychiatric explanation. Ask the physician if the claimant’s belief that s/he is unable to work despite the physician’s belief to the contrary might be due to medical or psychiatric conditions not considered by the physician.

b. Advise and assist the client in obtaining additional evaluations, if necessary.

c. If absolutely necessary, subpoena records.

Must request ALJ subpoena in writing 5 days in advance of hearing.

d. Review the claimant’s past jobs in the Dictionary of Occupational Titles.

e. Learn about the claimant’s impairments; read medical texts, study the medical records, look up medications; do whatever you need to understand the medical issues.

f. Consider and copy any case law you may want the ALJ to consider.

8. Preparation Checklist

a. Review and revise your theory of the case.

b. Make sure you have evidence to support your theory.

c. Abstract the file to determine what the issues are, what the evidence is, and whether the evidence is sufficient on each issue, and if not, what else you will need and how you will get it.

d. Note any discrepancies which need to be resolved with the client and his/her physician before the hearing and get them resolved.

e. Prepare questions for the hearing.
f. Review and revise your theory of the case again.

g. Draft a pre-hearing Memorandum or Written Summary of the case for the ALJ setting forth your theory of the case, and attach supporting evidence. If appropriate, consider requesting an on-the-record favorable decision. (Do not rely on testimony you expect the claimant or a witness to give, because it may not be given. Rely on what is actually in the record.)

D. Preparing the Claimant for the Hearing

a. Explain procedure; how the hearing will go. Make sure your client knows the date, time and place of the hearing, how to get there, and to get there at least a half hour in advance. Call the client the day before to remind him/her.

b. Review questions for hearing; including symptoms, daily activities, effects of medications/treatments.

c. Explain importance of detail and quantification (“I can only stand for 10 minutes” is better than “not very long”).

d. Advise client not to answer questions unless s/he understands question; to be sure to say if s/he doesn’t understand; to answer only what is asked.

e. Follow same procedure in general for any other potential witnesses at hearing.

Witness may corroborate limitations of activity or mental capacity (e.g., friends or family who assist or have observed claimant).

Medical or psychiatric experts. If you have them, be sure to obtain CV and be prepared to establish credentials for ALJ.

E. Post-Hearing Advocacy

1. If WON:

   Advocate and Client should both receive a copy of favorable decision.

   Social Security Administration (Baltimore office for SSD and local SSA office for SSI) must implement favorable decision.

   Send client a letter explaining what comes next: Notices of Awards, Request to come into local office (effectuation meeting), payment
of retroactive award and monthly benefits. See Manual containing sample post-hearing documents.

2. **If Lost:**

   Consider whether to represent client on appeal. (Remember that your agreement to represent the claimant was for the hearing only).

   Discuss with the client whether they want to re-apply for benefits or Request Review by Appeals Council. They cannot do both. See SSR 11-1p.

   If they choose to appeal, they have a 60 day time limit to file request for review. Write a detailed appeal brief/letter to the Appeals Council explaining why ALJ decision is wrong.

   Prerequisite for federal court appeal.
SAMPLE

Claimant Pam Smith (name and date of birth modified for her protection), date of birth 3/1/91.

GENERAL OUTCOME:

This is a basic background for a claimant. Her name, date of birth, and certain other details have been modified to protect her. The medical information, with some modification, is generally her story. My office submitted a written statement, along the lines of what follows below, to highlight her medical and physical impairments.

PSYCHIATRIC AND PHYSICAL ISSUES

On or about March 18, 2014, Ms. Smith was seen by the doctors at a nonprofit health and human services organization for a full assessment. Ms. Smith came to the appointment with her grandmother since she is unable to travel independently, especially on the subway, without an escort. In the assessment, it was determined that Ms. Smith had substantial functional limitations to employment due to medical conditions that will last for at least 12 months and make her unable to work. In particular, her ongoing medical and psychological conditions include Unspecified personality disorder, Post Traumatic Stress disorder, Mild mental retardation, Attention Deficit Disorder, Bipolar disorder, unspecified. Ms. Smith was referred for ongoing psychological assessments but later stopped because her therapist was a man and she did not feel comfortable seeing him or other male doctors for that matter. As she continues to see her psychologists, it became clear that Ms. Smith has persistent psychological issues.

She also has ongoing heart condition and is severely over-weight. All of these conditions were determined to be unstable and directly affect her ability to work. Due to her condition of Venous embolism and thrombosis, Ms. Smith is affected in her ability to sit and stand for extended periods. In fact, she is unable to walk more than 2 blocks at a time or to climb stairs. She often requires some assistance with bathing and dressing as well as general grooming, preparing meals and general household work. When she was 15 years of age, Ms. Smith suffered a heart attack. She was also raped. Ms. Smith subsequently suffered two suicide attempts which resulted in being hospitalized for approximately two weeks. Throughout her teenage years, she suffered significant incidents of physical abuse by a former boyfriend. Unfortunately, she did not meet with anyone and did
not receive proper treatment for these physical and emotional traumas for several years. At the moment, she is still unable to have medical treatment from male doctors.

For most of her teenage years, Ms. Smith was obese, weighing in at about 300 pounds. In July 2012, when she was diagnosed with cardiac ablation and paroxysmal ventricular tachycardia, a decision was made for her to undergo a procedure called Lap Band, to help reduce her weight. Following the surgery, Ms. Smith has reduced her weight but continues to receive medical updates, particularly to treat incidents of abdominal pain.

Incidentally, Ms. Smith has been evaluated and is now receiving treatment from a community health and human services agency. They completed a full scale IQ test and determined that her IQ fell at 63, which supported the claim of mild retardation. It was also determined that her history of sexual abuse and assault increased her level of fear and anxiety around people. Incidentally, when Ms. Smith was reevaluated in 2014, she had a lower IQ score of 46, which the doctors questioned and hoped to redo for accuracy since it was such a severe drop from a previous review.

**CONSULTATIVE EVALUATION**

In February, 2013, Ms. Smith met with Dr. X, from the social security department for a consultative evaluation. Ms. Smith came to the evaluation with her grandmother. It was determined that Ms. Smith graduated from High School but was in the special education program due to learning difficulties and behavioral issues. Due to ongoing psychiatric and medical problems, she has been unable to work. It was also noted that in 2006, Ms. Smith was hospitalized when she attempted to commit suicide by cutting her wrist with a razor. In 2007, she was again hospitalized due to severe depression. It was not until 2013, however, that she was able to see a psychiatrist from a nonprofit health and human services organization on a continual basis.

It was also noted that Ms. Smith has difficulty falling asleep and is often tired and sluggish. She has persistent moments of anxiety but has moments when she “feels as if she is on top of the world.” She often talks to herself. Her demeanor and responsiveness to questions was cooperative but immature. She had difficulty elaborating whatever she wanted to say and often relied on her grandmother. Her manner of relating, social skills and overall presentation was poor. When she was asked to do simple math, she used her fingers and Dr. X determined that she was mildly impaired in attention and concentration as well as recent and
remote memory skills. Her cognitive functioning was below average with fair insight and judgment.

Ms. Smith is able to dress herself but sometimes she needs assistance from her grandmother. Her grandmother does household chores and manages the money. Ms. Smith is unable to use public transportation and often uses Access-A-ride with her grandmother who uses a wheelchair. Dr. X determined that Ms. Smith is able to follow and understand simple directions and instructions, that she can perform simple tasks independently and has moderate limitation in maintaining attention and concentration. Dr. X further noted that Ms. Smith is able to maintain a regular schedule, that she exhibits moderate limitations in learning new tasks and performing complex tasks independently; that she exhibits mild to moderate limitations in making appropriate decisions, relating with others and adequately dealing with stress. Dr. X indicated that Ms. Smith’s difficulties are caused by mood instability and medical problems. The prognosis was listed as fair.

On the same day, Ms. Smith also met with Dr. Y, who examined her for the internal medicine consultative evaluation. Dr. Y indicated that Ms. Smith had a history of deep venous thrombosis in both legs since the age of 17. In 2012, she had a procedure for placement of a lap band, to decrease her weight. Ms. Smith does not cook but she is able to shower, bathe and dress herself. She was noted to have a fair prognosis. While Dr. Y noted that there were no objective outcomes to support a finding that Ms. Smith will be restricted in her ability to sit or stand or climb, push or pull, because of her history of dizzy spells, “the problem should be document.”

**ASSESSMENT OF THE ABOVE:**

The claimant was represented at the hearing by me and a volunteer attorney who I supervised on this case. During the process, I had him interview the claimant and ultimately prepare for the hearing. I also had him submit a written statement to me about the case. The statement was fully assessed and ultimately submitted to the ALJ, post hearing. The statement set forth the medical information in the record as well as statement testimony of the claimant and her grandmother from the hearing. The proposed solution was for a finding of disability which the ALJ granted in a written document filed several months later. At the hearing, the ALJ questioned the claimant and her grandmother as well as reviewed all of the information we submitted from the various treating sources.
Ultimately, the ALJ granted her a fully favorable determination. Specifically, the severity of her impairments meet listing 12.05C, which determines that a claimant has mental retardation initially manifested before age 22 with a valid, performance or full scale IQ of 60 through 70 and physical or mental impairment imposing additional and significant work-related limitation of function. Ms. Smith had a full scale IQ of 63 when she was evaluated in 2008. In 2014, she was again reevaluated and an IQ score of 46 was noted but with questions as to its full affect given the claimant’s demeanor at that moment.
SAMPLE LEGAL AID INTAKE INFORMATION
## LawManager Case Printout Report

### Civil Case Header Information

- **Case#**: 2014-012222
- **Client**: SMITH, P
- **Case**: Smith, Pam - 2014 - DAP
- **Case Type**: DAP Disability
- **Prob Code**: SSI Disability
- **Srvc Level**: Full Representation
- **Curr Office**: Harlem Community Law Office
- **Curr Unit**: <None>
- **Status**: Hold
- **Opened**: 10/23/2014
- **Closed**: <None>
- **Orig Office**: Harlem Community Law Office
- **Orig Unit**: <None>
- **Description**: Assisting with the case, Skadden Extern
- **Case Handler**: Willer, Edlyn L
- **Main Benefit**:
- **Secondary Fund**: 6 - Disability Advocacy Project (DAP)
- **Tertiary Fund**:
- **ACS Involvement**: N
- **Class Action**: N
- **Fund Escrow**: N
- **Group Representation**: N
- **Captions**: <None>
- **Case**: <None>
- **Reason Closed**: <None>

### Civil Client Intake Tab Information

- **First Name**: 
- **Middle Name**: 
- **Last Name**: Smith
- **Suffix**: 
- **Birth Date**: 3/1/1991
- **Gender**: Female
- **Facility**: 
- **Address Type**: Home
- **Street**: 123 Second Ave
- **Apt**: Apt
- **City**: New York
- **State**: NY
- **Zip Code**: 10009
- **Country**: New York
- **Phone**: (646) 123-4567
- **Requestor**: 
- **PA Center**: 
- **Referral Source**: 
- **Gender ID**: Female
- **Intake Type**: In Office
- **Living Arrangements**: Apartment - Not Doubled Up
- **Ethnic Origin**: Black
- **Race**: English
- **Language**: 
- **Hispanic**: N
- **Interpreter Needed**: N
- **DIN**: 
- **Alien Reg#**: 
- **Book & Case #**: 
- **Work Phone**: 
- **Requestor Relationship**: 
- **PA Case #**: 
- **Email**: 
- **Retro Benefit**: $4,669.46
- **Monthly Benefit**: 
- **Amount Avoided**: 
- **Archive Box**: 
- **Date Added**: 10/23/2014 10:42 AM
- **Date Updated**: 6/17/2015 5:41 PM
- **Date Printed**: 12/16/2015 1:11 PM
SSA FORMS

• Appointment of Rep or 1696: https://www.ssa.gov/forms/ssv-1696.pdf:
Consent for Release of Information  

You must complete all required fields. We will not honor your request unless all required fields are completed. (*signifies a required field).  

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:  

*ADDRESS OF PERSON OR ORGANIZATION:  

*I want this information released because:  

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

*Please release the following information selected from the list below:  

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.  

1. [ ] 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 (you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)  

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 any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain 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:  

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)  

Form SSA-3288 (07-2013) EF (07-2013)
Social Security Administration

Please read the instructions before completing this form.

Name (Claimant) (Print or Type) PAM Smith
Wage Earner (If Different) 123-45-6789

Social Security Number

Part I

APPOINTMENT OF REPRESENTATIVE

I appoint this person, Edlyn Willer, The Legal Aid Society, Harlem Community Law Office, 230 E. 106th Street, Manhattan, NY 10029, to act as my representative in connection with my claim(s) or asserted right(s) under:

- Title II
- Title XVI
- Title XVIII
- Title VIII (Medicare Coverage)
- Title VIII (SSI) (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

Signature (Claimant)
Address

Telephone Number (With Area Code) (646) 123-4567
Fax Number (With Area Code)

Date December 16, 2015

Part II

ACCEPTANCE OF APPOINTMENT

I, Edlyn Willer, 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 The Legal Aid Society, Harlem Community Law Office, 230 E. 106th Street, Manhattan, NY 10029

Telephone Number (With Area Code) (212) 426-3094
Fax Number (With Area Code) (646) 616-9418

Date December 16, 2015

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.)

☐ 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 205 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 or services provided in connection with their claim(s) or asserted right(s).

Signature (Representative) Date December 16, 2015

Form SSA-1696-U4 (03-2011) ef (03-2011) TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS
(4 Copies: File, Claimant, Representative, ODAR)
Release to Get Medical Information

- The form generally used is NYCHH HIPPA Release which may be on file or it may be obtained directly from the New York State Department of Health or [https://www.health.ny.gov/forms/doh-5032.pdf](https://www.health.ny.gov/forms/doh-5032.pdf)
**NYCHC HIPAA Authorization to Disclose Health Information**

**ALL FIELDS MUST BE COMPLETED**

<table>
<thead>
<tr>
<th>PATIENT NAME/ADDRESS</th>
<th>DATE OF BIRTH</th>
<th>PATIENT SSN</th>
<th>MEDICAL RECORD NUMBER</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>P. Smith</td>
<td>3/1/1991</td>
<td>123-45-6789</td>
<td>(646) 123-4555</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF HEALTH PROVIDER TO RELEASE INFORMATION</th>
<th>SPECIFIC INFORMATION TO BE RELEASED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Legal Aid Society</td>
<td>Information Requested: ENTIRE MEDICAL RECORD</td>
</tr>
<tr>
<td>Edlyn Willer</td>
<td></td>
</tr>
<tr>
<td>Staff Attorney</td>
<td>Treatment Dates from ____________ to ____________</td>
</tr>
<tr>
<td>Harlem Community Law Office</td>
<td></td>
</tr>
<tr>
<td>Manhattan, NY 10029</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME &amp; ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and/or Substance Abuse</td>
</tr>
<tr>
<td>Genetic Testing Information</td>
</tr>
<tr>
<td>Mental Health Information</td>
</tr>
<tr>
<td>HIV/AIDS-related Information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REASON FOR RELEASE OF INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Matter</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event:</td>
</tr>
</tbody>
</table>

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I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to ALCOHOL or SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH, and/or CONFIDENTIAL HIV/AIDS RELATED INFORMATION, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2400 or the New York City Commission of Human Rights at 212.366.4500. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

<table>
<thead>
<tr>
<th>SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF NOT PATIENT, PRINT NAME &amp; CONTACT INFORMATION OF PERSONAL REPRESENTATIVE:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>DESCRIPTION OF PERSONAL REPRESENTATIVE’S AUTHORITY TO ACT ON BEHALF OF PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 16, 2015</td>
<td></td>
</tr>
</tbody>
</table>

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.
# Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Patient Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

   1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT; MENTAL HEALTH TREATMENT; and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in Item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.

   2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3444. This agency is responsible for protecting my rights.

   3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

   4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

   5. Name and Address of Provider or Entity to Release this Information:

   6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

   7. Purpose for Release of Information:

   8. Unless previously revoked by me, the specific information below may be disclosed from: [INSERT START DATE] until [INSERT EXPANSION DATE OR EVENT]

   - All health information (written and oral), except:

<table>
<thead>
<tr>
<th>Information to be Disclosed</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records from alcohol/drug treatment programs</td>
<td></td>
</tr>
<tr>
<td>Clinical records from mental health programs</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS-related Information</td>
<td></td>
</tr>
</tbody>
</table>

   9. If not the patient, name of person signing form:

   10. Authority to sign on behalf of patient:

   All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

   **Witness Statement/Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient’s authorized representative.

   **Staff Person's Name and Title:**

   **Signature:**

   **Date:**

This form may be used in place of DOH-2007 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DOH-5022 (4/11)