SSDA USE ONLY

Please PRINT Claimant's Name_____

SSDA Representative Name_____

SSDA Signature Sheet

I _____ hereby on _____/_____/2025 allow Social Security Disability Advocates, including Gail Smith and Russell Behjatnia to complete my Social Security Claim with my signature on any paperwork that is presented in their current signature package listed below. They can act on behalf of all manners relating to Social Security Disability Insurance Benefits and/ or Supplemental Social Security Income Benefits, including signing of all documents relating to these matters. Any and all acts carried out by Gail Smith and Russell Behjatnia on my behalf, shall have the same effects as acts of my / our own.

SSDA Signature Package

1. SSA-16-F6
2. SSA-8000-BK
3. SSA-8001-BK
4. SSA-8000-F5
5. SSA -1696 (Appointment of Representation-Gail Smith)
6. SSA-1696 (Appointment of Representation-Russell Behjatnia)
7. SSA-561 Request for Reconsideration
8. SSA-501 Request for Hearing
9. SSA-1560 (Fee Petition)
10. Fee Agreement (Russell Behjatnia)
11. SSA-3288
12. SSA-827
13. Authorization for Request or Use / Disclosure of Protected Health Information

SOCIAL SECURITY ADVOCATES WILL NOT BE HELD ACCOUNTABLE FOR RECORDS LEFT IN OUR OFFICE FOR LONGER THAN 30 DAYS.

Any records left in our office for longer than 30 days will be disposed of.

By signing below, I agree that I have read Social Security Disability Advocates Signature Package and understand what the forms listed above represent. I will abide by the agreements that are stated in these forms.

_____

_____

PLEASE SIGN IN THE MIDDLE OF THE BOX NOT TOUCHING THE BORDER

61. IMPORTANT INFORMATION - PLEASE READ CAREFULLY

- Failure to report any change within 10 days after the end of the month in which the change occurs could result in a penalty deduction.
- The Social Security Administration will check your statements and compare its records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount.
- We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs:
  - (1) you or your spouse notify us in writing that you are canceling your permission,
  - (2) your application for SSI is denied in a final decision,
  - (3) your eligibility for SSI terminates, or
  - (4) we no longer consider your spouse's income and resources to be available to you.

If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

62. 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. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

Your Signature (First name, middle initial, last name) (Sign in ink.)	Date (MM/DD/YYYY)
	Telephone Number(s) where we can contact you during the day:

Spouse's Signature **(Sign only if applying for payments.)** (First name, middle initial, last name) (Sign in ink.)

63. If you are blind or visually impaired, check the type of mail you want to receive from us.

- ☐ Standard notice First Class
- ☐ Standard notice First-Class with a follow-up phone call
- ☐ Standard notice & data CD by First-Class
- ☐ Standard notice Certified
- ☐ Standard & Braille notices by First-Class
- ☐ Standard & large print notices
- ☐ Standard notice & audio CD

64. **WITNESS**

Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing who know you, must sign below giving their full address.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

REQUEST FOR RECONSIDERATION

NAME OF CLAIMANT:	CLAIMANT SSN:	CLAIM NUMBER: *(If different than SSN)*

ISSUE BEING APPEALED: *(Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)*

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration.
My reasons are:

SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY

THREE WAYS TO APPEAL

I want to appeal your determination about my claim for **SSI** or **SVB**. I have read about the three ways to appeal.
I have checked the box below:

☐ **CASE REVIEW** - **You can pick this kind of appeal in all cases**. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.

☐ **INFORMAL CONFERENCE** - **You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment.** You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

☐ **FORMAL CONFERENCE** - **You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment.** This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

CONTACT INFORMATION

CLAIMANT SIGNATURE - *OPTIONAL:*			NAME OF CLAIMANT'S REPRESENTATIVE: *(If any)* Russell Behjatnia		
MAILING ADDRESS:			MAILING ADDRESS: 4508-A Atlantic Avenue Ste 777		
CITY:	STATE:	ZIP CODE:	CITY: Long Beach	STATE: Ca	ZIP CODE: 90807
TELEPHONE NUMBER: *(Include area code)*	DATE:		TELEPHONE NUMBER: *(Include area code)* (800) 887-7984	DATE:	

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ Yes ☐ No

2. IS THIS REQUEST FILED TIMELY? ☐ Yes ☐ No

(If "NO", attach claimant's explanation for delay. Refer to GN 03101.020)

FIELD OFFICE DEVELOPMENT (GN 03102.300)

☐ NO FURTHER DEVELOPMENT REQUIRED

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS AND DATE APPEAL RECEIVED:

SSI CASES ONLY - GOLDBERG KELLY (GK)

(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

☐ WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;

☐ AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT

☐ PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claims Folder

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

1. Claimant Name	2. Claimant SSN	3. Claim Number, if different

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

An Administrative Law Judge of the Social Security Administration's Office of Hearings Operations or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 75 days before the date of hearing from the Social Security Administration, and 20 days before the date of hearing from the Department of Health and Human Services.

5. I have additional evidence to submit. ☐ Yes ☐ No

Name and source of additional evidence, if not included.

Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.

6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks

☐ I wish to appear at a hearing.

☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

Representation: You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL)	DATE	8. NAME OF REPRESENTATIVE (if any)	DATE
		Russell Behjatnia	

RESIDENCE ADDRESS			ADDRESS		
			4508-A Atlantic Ave Ste 777		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
			Long Beach	Ca	90807
TELEPHONE NUMBER	FAX NUMBER		TELEPHONE NUMBER	FAX NUMBER	
			(800)887-7984	(562)472-2270	

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING

9. Request received on _____ (Date) by: _____ (Print Name) (Title)

_____ (Address) (Servicing FO Code) (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? ☐ Yes ☐ No

If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? ☐ Yes ☐ No

12. Interpreter needed ☐ Yes ☐ No

Language (including sign language):

13. Check one: ☐ Initial Entitlement Case

☐ Disability Cessation Case or ☐ Other Postentitlement Case

14. HO COPY SENT TO: _____ HO on _____

☐ Claims Folder (CF) Attached: ☐ Title (T) II; ☐ T XVI; ☐ T VIII; ☐ T XVIII; ☐ T II CF held in FO ☐ Electronic Folder

☐ CF requested ☐ T II; ☐ T XVI; ☐ T VIII; ☐ T XVIII

(Copy of email or phone report attached)

16. CF COPY SENT TO: _____ HO on _____

☐ CF Attached: ☐ Title (T) II; ☐ T XVI; ☐ T XVIII

☐ Other Attached: _____

15. Check all claim types that apply:

☐ Retirement and Survivors Insurance Only	(RSI)
☐ Title II Disability - Worker or child only	(DIWC)
☐ Title II Disability - Widow(er) only	(DIWW)
☐ Title XVI (SSI) Aged only	(SSIA)
☐ Title XVI Blind only	(SSIB)
☐ Title XVI Disability only	(SSID)
☐ Title XVI/Title II Concurrent Aged Claim	(SSAC)
☐ Title XVI/Title II Concurrent Blind	(SSBC)
☐ Title XVI/Title II Concurrent Disability	(SSDC)
☐ Title XVIII Hospital/Supplementary Insurance	(HI/SMI)
☐ Title VIII Only Special Veterans Benefits	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify:	

Claimant's Social Security Number

			-		-				

Appointed Representative's Rep ID

Section 6 - Claim Type *(Claimant or Representative)*

I appoint the individual named in Section 4 to act as my representative in connection with my claim(s) or asserted right(s) under Title II (RSDI), Title XVI (SSI), Title XVIII (Medicare Coverage), and Title VIII (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (*Check all that apply*)

- ☐ Claim/Appeal for Title II Disability Benefits
- ☐ Claim/Appeal for Title XVI Disability Benefits
- ☐ Concurrent Title II and Title XVI Disability Benefits
- ☐ Claim/Appeal for Retirement Benefits
- ☐ Claim/Appeal for Title XVIII (Medicare), VIII (Special Veteran's Benefits)
- ☐ Continuing Disability Review (CDR)
- ☐ Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

Section 7 - Fee Arrangement *(Claimant Only)*

Check one box below:

- ☐ **I will request a fee and direct payment of this fee.** Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. *(We must authorize the fee.)*
- ☐ **I will request a fee but not direct payment.** Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. *(We must authorize the fee.)*
- ☐ **I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual.** Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. *(We do not need to authorize the fee if all regulatory conditions apply.)*
- ☐ **I waive the right to a fee.**

Section 8 - Signatures *(Claimant and Representative)*

Representative's Signature	**Date**
Claimant's Signature	**Date**

Claimant's Social Security Number

			-		-				

Representative's Rep ID

Standard Fee Agreement

If SSA favorably decides my claim(s) and the decision results in past-due (retroactive) benefits, I agree to pay my representative(s) a fee that does not exceed the lesser of 25 percent of my past-due benefits or the maximum dollar amount allowed under the Social Security Act Section 206(a)(2), or such higher amount set by the Commissioner of Social Security base on the date Social Security Administration (SSA) authorizes my representative's fee.

Choose One:

☒ I agree to pay the maximum fee as stated in the preceding paragraph ($7,200 as of November 30, 2022).

☐ I agree to pay less than the maximum $ _____ or _____ %.

Read and acknowledge the following:

I understand that, subject to the maximum dollar amount in effect, SSA also may authorize fees to my representative based on past-due benefits awarded to my unrepresented spouse or any unrepresented auxiliary beneficiary.

I understand that I, my eligible spouse, any affected auxiliary beneficiary, my representative or the decision maker have the right to protest the fee authorized under this fee agreement, in writing, within 15 days from the authorization.

I understand that my representative may still request a fee even if my case does not result in past-due benefits, or the decision i not favorable. If the fee agreement cannot be approved because there are no past-due benefits or for other reasons, my representative may file a fee petition to request that SSA authorize a fee. I also understand that if there are no past-due benefits withheld, if not enough past-due benefits are withheld, or if my representative is not eligible for direct payment by SSA, I will be responsible to pay the authorized fee to my representative(s) directly. SSA does not authorize out-of-pocket costs and expenses for which I am responsible to pay directly to my representative.

Claimant's Initials ____

Two-Tiered Fee Agreement (Optional)

Only complete this section if you and your representative(s) have chosen to limit the effect of this fee agreement to to a certain administrative level.

If SSA favorably decides my claim(s) above the _____ administrative level, this fee agreement is void and my representative(s) may seek a higher fee by filing a fee petition. SSA must authorize this fee.

Escrow/Trust Accounts or Third-party Payments (Optional)

Only complete this section if your representative(s) will use an escrow or trust account, or someone other than you or your spouse, dependents or auxiliary beneficiaries or another individual has paid or will pay your representative a fee.

☐ With my consent my representative(s) has/have or will establish an escrow/trust account in the amount of $ _____

☐ My representative will receive a fee from another party (e.g., state, county, private entity) for $ _____ and I will have no financial responsibility to pay any fee, unless SSA authorizes the total fee.

Only representatives who have been properly appointed can be authorized to receive a fee. The claimant and any appointed representative not waiving a fee are each required to sign this fee agreement.

Claimant and Representative Signatures

Claimant's Signature _____ Date _____

Representative's Signature _____ Date _____

NAME (First, Middle, Last, Suffix)

SSN	Birthday *(MM/DD/YYYY)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT **All my medical records: also education records and other information related to my ability to perform tasks. This includes Specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited**
   - 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 ident 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 internationa 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 SS/ definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY
INDIVIDUAL authorizing disclosure - Signature

IF not signed by subject of disclosure, specify basis for authority to sign
☐ Parent of minor ☐ Other personal representative (explain) _____
☐ Guardian

(Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS I know the person signing this form or am satisfied of this person's identity:

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

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other informatic 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.

[illegible]

[illegible] complete all required fields. We will not [illegible] required field. ** These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case [illegible] need to contact you about the consent form).

TO: Social Security Administration

*Full Name	*Date of Birth (MM/DD/YYYY)	*Full 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: ** PHONE NUMBER OF PERSON OR ORGANIZATION:
Gail Smith	4508-A Atlantic Ste 777
Marthel	Long Beach, California 90807
Gina	

***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:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☒ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☒ Social Security benefit amounts from date ________ to date ________
5. ☒ Supplemental Security Income payment amounts from date ________ to date ________
6. ☒ Medicare entitlement from date ________ to date ________
7. ☒ Medical records from date ________ to date ________
8. ☒ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)
   Status of claim

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 § 1746) that I have examine all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by fine of up to $5,000.

***Signature:** ______________________ ***Date:** ________

****Address:** ______________________ ****Daytime Phone:** ________

****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 tl signature line above.

1.Signature of witness	2.Signature of witness
Address (Number and street,City,State, and ZIP Code)	Address (Number and street,City,State, and ZIP Code)