Diana P. Wade
ACCREDITED DISABILITY REPRESENTATIVE

**661-821-0494 – FAX 661 821- 2085**

**From Mono, Inyo and KERN RIVER VALLEY AND RIDGECREST AREA**

**call cell-to-cell 760-417-2390**

Re: Social Security Disability/SSI **KEEP FOR REFERENCE FUTURE**

Dear Potential Client:

Thank you for your interest in my consulting service. This letter will explain how my service works and offer a few easy instructions to how you can begin using my services immediately. As you may already know, my business is helping people enhance their chances of winning their Social Security disability benefits.

There are two kinds of Social Security Disability programs. If you have ever worked at a job, you have paid into the system of Social Security Disability. SSI is a federal welfare program. If you are low income and not eligible for other Social Security programs, you might qualify for SSI. In either case, you deserve the best possible chance to receive benefits if you are totally disabled. Both programs require a person to be medically disabled under the Social Security Guidelines. There are slight differences to both programs. I will go over those items after you fill out and complete the questionnaire if you have any questions about which one concerns you.

You may have already discovered that just applying for benefits is not enough. The Social Security disability system is complex with many ways of being denied. If you truly believe you are disabled, you must be willing to fight for your benefits. However, it would not be wise to tackle SSA alone. You need the help of those who have been specifically trained dealing with the Social Security disability system. ***Many attorneys are not trained to handle these types of cases and may require a large up-front retainer.***

I believe I have a more effective way of fighting for your rights. I do not charge an up-front fee, just 25% of the back benefits, with a maximum of $6,000.00 (there are exceptions for continuing disability reviews). Your future monthly benefits will not be affected. In return, I will act as your authorized representative before the Social Security Administration. Representation will assure that your case receives fair consideration from SSA. You only pay this fee if I win your case. There is no obligation if I lose.

29930 Skyline Drive, Tehachapi, California 93561 • Tel: 661.821.0494 • Fax: 661.821.2085 • Tel: 800.356.7456
Email: dianapwade@att.net • www.CaliforniaDisability.net

Another exciting feature of my service is that you can enjoy the best possible representation without having to leave your home. I can handle all the important aspects of your case primarily by mail, while keeping you informed of what is happening in your case. You will be notified by mail or email of all-important actions I take on your behalf.

As part of my service, I will also guide your case through each of the appeals processes. Using my knowledge of the disability program, I will act whenever possible to speed up your case so that you receive your decision faster. I will carefully review the evidence in your case and where possible, formulate a written argument on your behalf. You may receive a copy of your case argument at the same time it is sent to SSA.

It is important that you understand I cannot guarantee that your case will be won as a result of my actions. However, if your case is denied on the reconsideration level while being handled by me, I will automatically apply and present your case before the Administrative Law Judge. You do not have to do anything except sign forms and attend an examination if ordered to do so by SSA. If a formal hearing is required, I will be there with you to represent you and will prepare your case to present to the administrative law judge. I will act as your personal advisor during the reconsideration and ALJ levels of your case and protect you as much as possible from being misled or overlooked by SSA.

According to SSA statistics, claimants get better results if they are represented.

If you would like to start my service, take a few moments to sign, date and return the forms supplied in this packet. Return them to me along with the SSA Representation Form. I will formally present a request to represent your case to SSA and request copies of all your medical records for review. If there are any further questions regarding my service, please feel free to call me. Thank you for thinking of choosing me.

Very truly yours,

*Diana P. Wade,* ADR


PS If you have received a denial from Social Security, the last day to file your appeal is 60 days from the date of the denial letter. Be sure to send me copies of what you sent to, and received from, SSA.

# Diana P. Wade

Non-Attorney Representative
29930 Skyline Drive
Tehachapi, CA 93561
661 821 0494


## EDUCATION:

1. Received double B.A. in Sociology and Human Studies from California State University, Dominguez Hills, 1980. *Summa cum laude.*
2. Received Certificate of Completion in Public Paralegal Studies from California State University, Dominguez Hills, 1980, with honors. Interned with Bet Tzedek Legal Services 1978 and 1979.

Attended several continuing education seminars on disability representation offered by NOSSCR and NADR. Taught workshops on brief writing and hearing preparation for the California Association of Legal Document Assistants ("CALDA"), formerly known as California Association of Independent Paralegals. Presented a mock hearing October 2000 and 2006 at annual CALDA conference. Presented a basic SSA how to workshop in Madera, CA 2001. Taught class on disability determination at annual CALDA conferences 2002, 2003 and 2005.

## EMPLOYMENT:

1. Employed in Los Angeles from 1980 to 1984 by Paul, Hastings, Janofsky & Walker and from 1984 to 1988 by Sachs & Phelps as a corporate/securities paralegal specializing in Blue Sky qualifications.
2. Provided free lance paralegal services 1988 to 1998 for local attorneys
3. Owner/operator of legal document typing service from 1990 to 2005).
4. Accredited Disability Advocate and eligible for Direct Payment of fees by SSA beginning 1995 to the present providing representation in front of the Social Security Administration. Handled hundreds of cases from initial applications through to the Appeals Council level throughout Central California.

## PROFESSIONAL AFFILIATIONS:

1. Member California Association of Legal Document Assistants since 1992. Served on CALDA's Board of Directors from 1995 to 2003. President of CALDA 2002 and 2003. Currently serving on the Advisory Board.
2. Member of NOSSCR since 1997.
3. Founding member of National Association of Disability Representatives (NADR) 2000.

**INFORMATION FOR CLAIMANTS** **What a Representative May Do**

We will work directly with your appointed representative unless he or she asks us to work directly with you. Your representative may:

- get information from your claim(s) file;
- give us evidence or information to support your claim;
- come with you, or for you, to any interview, conference, or hearing you have with us;
- request a reconsideration, hearing, or Appeals Council review; and
- help you and your witnesses prepare for a hearing and question any witnesses.

Also, your representative will receive a copy of the decision(s) we make on your claim(s). We will rely on your representative to tell you about the status of your claim(s), but you still may call or visit us for information.

You and your representative(s) are responsible for giving Social Security accurate information. It is wrong to knowingly and willingly furnish false information. Doing so may result in criminal prosecution.

We usually continue to work with your representative until (1) you tell us that he or she no longer represents you; or (2) your representative tells us that he or she is withdrawing or indicates that his or her services have ended (for example, by filing a fee petition or not pursuing an appeal). We do not continue to work with someone who is suspended or disqualified from representing claimants.

**What Your Representative(s) May Charge**

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our approval. (Even when someone else will pay the fee for you, for example, an insurance company, your representative usually must get our approval.) One way is to file a fee petition. The other way is to file a fee agreement with us. In either case, your representative cannot charge you more than the fee amount we approve. If he or she does, promptly report this to your Social Security office. Please do this within 20 days of receiving your copy of the petition.

We will review the petition and consider the reasonable value of the services provided. Then we will tell you in writing the amount of the fee we approve.

- **Filing A Fee Agreement**
  If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if you both signed it; the fee you agreed on is no more than 25 percent of past-due benefits, or $6,000 (or a higher amount we set and announced in the Federal Register), whichever is less; we approve your claim(s); and your claim results in past-due benefits. We will tell you in writing the amount of the fee your representative can charge based on the agreement.

  If we do not approve the fee agreement, we will tell you and your representative in writing. Then your representative must file a fee petition to charge and collect a fee.

After we tell you the amount of the fee your representative can charge, you or your representative can ask us to look at it again if either or both of you disagree with the amount. (If we approved a fee agreement, the person who decided your claim(s) also may ask us to lower the amount.) Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

**How Much You Pay**

You never owe more than the fee we approve, except for:

- any fee a Federal court allows for your representative's services before it; and
- out-of-pocket expenses your representative incurs or expects to incur, for example, the cost of getting your doctor's or hospital's records. Our approval is not needed for such expenses.

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. If an attorney or a non-attorney who is eligible to receive direct fee payment represents you, and if your retirement, survivors, disability insurance, and/or supplemental security income claim(s) results in past-due benefits, we usually withhold 25 percent of your past-due benefits to pay toward the fee for you.

You must pay your representative directly:

- the rest of the fee you owe
  - if the amount of the fee is more than any amount(s) your representative held for you in a trust or escrow account and we withheld and paid your representative for you.
- all of the fee you owe
  - if we did not withhold past-due benefits, for example, because your representative waived direct payment, or you discharged the representative, or the representative withdrew from representing you before we issued a favorable decision; or if we withheld, but later paid you the money because your representative did not either ask for our approval until after 60 days of the date of your notice of award or tell us on time that he or she planned to ask for a fee.

***PLEASE RETURN TO***
***DIANA P. WADE***
***Disability Advocate and Representative***
***DISABILITY ADVOCATES OF CENTRAL CALIFORNIA, INC.***
29930 Skyline Drive
Tehachapi, CA 93561
(661) 821-0494 -- FAX 661 821 2085

**760 area code and text messaging 760-417- 2390**

# *SOCIAL SECURITY DISABILITY/SSI QUESTIONNAIRE*

***Please complete carefully and thoroughly***

| | |
|---|---|
| NAME: | TELEPHONE:<br><br>MESSAGE number of someone that has constant contact: |
| ADDRESS:<br><br>Email: | SSN:<br><br>DATE OF BIRTH: AGE: |

Please circle the item that applies to your case:

1. I have not contacted Social Security
2. I have a telephone interview on _____
3. I have filed my initial application but I have not heard anything.
4. I have received my first denial dated _____
5. I have appealed my first denial and filed the Request for Reconsideration _____
6. I have received my second denial dated _____
7. I have filed a Request for Hearing _____
8. I have a hearing scheduled _____
9. I have denied benefits by a judge on _____
10. I have filed an appeal with the Appeals Council _____
11. I have been denied by the Appeals Council on _____
12. I need to file a Federal Appeal

** PLEASE ATTACH COPIES OF ANY NOTICES YOU RECEIVED FROM SOCIAL SECURITY!!

# MEDICAL AND JOB WORKSHEET – ADULT

This worksheet is intended for information purposes only in order to determine case qualifications for Diana P. Wade, Disability Advocate.

BIOGRAPHICAL

Your Height: _____ Your Weight: _____

Are you Right or Left-handed? _____

Did you serve on Active Duty in the U. S. Military? (circle one) Yes No

Where were you born? (city and state) _____, _____

Are you married? (circle one) Yes No

When did you become unable to work? (month/day/year) _____

What medical conditions, illness or injuries limit your ability to work (please be specific)

_____

_____

_____

_____

_____

Are you collecting State Disability or Workers' Comp (circle one) Yes No

**If yes, I will need the notice of exhaustion from SDI or the Compromise and Release from WC.**

Are you working now, even part time? (circle one) Yes No

Do you have a medical Marijuana card? (circle one) Yes No

Date: _____ Sign: _____

On Each Of The Following Pages – Please Sign Your NAME or initials ONLY where I have highlighted in Yellow.

Do Not Fill Out Any Of The Other Listed Information.

I will fill the information out for you as I need it and submit requests for medical records.

Thank You in advance for your cooperation.

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

Form Approved
OMB No. 0960-0527

| Name (Claimant) (Print or Type) | Social Security Number |
|---|---|
| Wage Earner (If Different) | Social Security Number |

**Part 1 APPOINTMENT OF REPRESENTATIVE**

I appoint this person, Diana P. Wade, 29930 Skyline Drive, Tehachapi, CA 93561 (Name and Address) to act as my representative in connection with my claim(s) or asserted right(s) under:

XX Title II (RSDI) XX Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designate associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copy services) for or with my representative

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

| Signature (Claimant) | Address |
|---|---|
| Telephone Number (with Area Code) | Fax Number (with Area Code) Date |

**Part II ACCEPTANCE OF APPOINTMENT**

I, **Diana P. Wade**, 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 II satisfies this requirement).

Check one: ☐ I am an attorney. **XX I am a non-attorney who is participating in the direct fee payment**

☐ I am not an attorney. I am not participating in the direct fee payment demonstration project..

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES XX NO

I have been disqualified from participating in or appearing before a Federal program or agency. ☐ YES XX 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<br>29930 Skyline Drive, Tehachapi, CA 93561 |
|---|---|
| Telephone Number (with Area Code)<br>661 821 0494 | Fax Number (with Area Code) Date<br>661-821-2085 |

**Part III FEE ARRANGEMENT**

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

[XX] **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.)*

[ ] **Charging a fee but waiving direct payment of the fee from withheld past-due benefits** – I do not qualify for or do not want request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

[ ] **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** – By checking this block I certify that my fee will be paid by a third-party, and that 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 paid by a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

[ ] **Waiving fees from any source** – I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative) Date

Diana P. Wade
ACCREDITED DISABILITY REPRESENTATIVE

## STANDARD FEE AGREEMENT SOCIAL SECURITY DISABILITY/SSI

REPRESENTATIVE'S FEE: I employ Diana P. Wade to represent me before the Social Security Administration in my Social Security Disability case, Supplemental Security Income (SSI) case, or both. If I win, **I agree that my representative's fee will be twenty five percent (25%) of all past-due benefits awarded to me and my family, or $6,000.00, (or the maximum allowed per 206(a)(2)(A) and 1631(d)(2)(A) of the Act), whichever is less**. I understand that the representative's fee depends on winning my case. If I do not win benefits, then the representative does NOT get a fee.

**PAYMENT OF REPRESENTATIVE'S FEE**). I understand that Social Security will deduct the approved fees from my retroactive benefits and pay them directly to her. In the event my retroactive benefits are released in installments, I understand that Social Security will deduct and pay Ms Wade's fee in full, prior to the release of the first installment. I understand that changes in the law have enabled Ms. Wade to have her full fee withheld from my lump sum benefits and paid directly to her by the Social Security Administration, and I authorize the Social Security Administration to process her fees in this manner.

In the event I elect to discharge my representative prior to receiving a final decision on my claim and my claim is subsequently approved, my representative retains the right to file a fee petition with the Social Security Administration for approval of reasonable fees for all services rendered up to the date of discharge. I understand that Social Security will pay my representative any fees authorized on an approved fee petition. In the event Social Security fails to withhold and pay my representative's fees in accordance with the law and this agreement, I understand that I will be financially responsible for payment of those fees to my representative in full, and/or that Social Security may reduce my ongoing monthly payment, in order to pay my representative. If I fail to pay the approved fees in accordance with this agreement, I understand that my representative will take whatever legal recourse is necessary to collect the fees approved by the Social Security Administration, in accordance with State and Federal laws. If my representative withdraws voluntarily from my claim, she agrees to waive her right to charge or collect a fee, but I agree to immediately reimburse her for all expenses incurred to date.

**I WILL PAY EXPENSES:** In addition to the representative's fee, I agree to pay my representative for reasonable expenses that they pay in my case. These **may** include long distance telephone calls, medical records and reports, photocopying, travel expenses, and the like. I will get a bill for these expenses that show how and when my representative spent the money. In a case in which I get benefits, I agree to pay my representative back for these expenses as soon as I get my lump sum check for past due benefits. I agree to pay expenses whether we win or lose.

**I HAVE NOT BEEN PROMISED THAT I WILL WIN.** My representative promised that she will do her best to help me. She did not promise that I will win.

I accept and approve this agreement:

_____ SSN: _____DATED: _____

Claimant's Signature

_____

Diana P. Wade, Representative

29930 Skyline Drive, Tehachapi, California 93561 • Tel: 661.821.0494 • Fax: 661.821.2085 • Tel: 800.356.7456
Email: dianapwade@att.net • www.CaliforniaDisability.net

## Authorization for Disclosure of Protected Health Information

I, _____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

Name(s) _____
Organization(s) _____
Address _____

I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above.

Name(s)
Diana P. Wade, Disability Advocate, 29930 Skyline Rd, Tehachapi, CA 93561
661-821-0494

**Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate): ALL RECORDS, INCLUDING, BUT NOT LIMITED TO all medical and psychiatric doctor's reports, hospital admissions and discharge summaries, consultative examinations, X-ray results, drug and/or alcohol treatment notes, and any special testing of any type, if available.**

Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space): At the request of the individual INITIAL ____ [X] MENTAL HEALTH , HIV, ALCOHOL.DRUG

I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

This authorization expires on ___NA___, or in the event that, FINAL ADJUDICATION OF MY Social Security Disability benefits case, whichever occurs first.

Treatment, payment, continued enrollment in a health plan or eligibility for benefits will not be conditioned upon the individual's provision of authorization (except as allowed by federal and/or state law) [45 CFR (6)(c)(2)(ii)].

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signed: _____ DOB: _____
Name: _____
Address: _____
Telephone: _____ Social Security No.: _____

_____
Relationship or Authority of Personal Representative (if applicable)

[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508. [1] These laws apply to health plans, health care providers, and health care clearinghouses.

## Authorization for Disclosure of Protected Health Information
## Psychotherapy Notes Only

I, _____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

Name(s) _____
Organization(s) _____
Address _____

I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above.

Name(s)

Diana P. Wade, Disability Advocate, 29930 Skyline Rd., Tehachapi, CA 93561-
661 821 0494

**Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate): ALL RECORDS, INCLUDING, BUT NOT LIMITED TO charts, physician's progress notes, laboratory reports, x-ray and radiological reports, other diagnostic testing, consultation reports, psychiatric/psychological records, reports and testing, records pertaining to treatment for HIV/AIDS, drugs or alcohol, and such information as you may have concerning medical/mental health diagnoses, treatment, medications, prognosis and impressions)**

Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space): At the request of the individual INITIAL ____ [X] MENTAL HEALTH , HIV, ALCOHOL.DRUG

I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

Treatment, payment, continued enrollment in a health plan or eligibility for benefits will not be conditioned upon the individual's provision of authorization (except as allowed by federal and/or state law) [45 CFR (6)(c)(2)(ii)].

This authorization expires on ___NA___, or in the event that, FINAL ADJUDICATION OF MY Social Security Disability benefits case, whichever occurs first.
I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ DOB: _____
Signed

Name: _____
Address: _____
Telephone: _____ Social Security No.: _____

_____
Relationship or Authority of Personal Representative (if applicable)

[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508.
[1] These laws apply to health plans, health care providers, and health care clearinghouses.

# AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS

TO:

Dear Sir or Madam:

You are hereby authorized to release any and all records, which you have concerning the undersigned (including but not limited to academic records, evaluation records, attendance records and discipline records), to Diana P. Wade. You are authorized to discuss the above matters with her and to permit her to examine and make copies of records pertaining to the above named person.

A photocopy of this authorization shall serve the same purpose as an original.

_____

Signature
Soc. Sec. No.:
Date of Birth:

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO:

Dear Sir or Madam:

You are hereby authorized to release any and all employment records which you have concerning _____(including but not limited to personnel records, payroll records, attendance records, evaluation records, insurance benefits, profit sharing, pension plans or retirement benefits), to Diana P. Wade. You are authorized to discuss the above matters with them and to permit them to examine and make copies of records pertaining to the above named person.

A photocopy of this authorization shall serve the same purpose as an original.

_____

Signature
Soc. Sec. No.:
Date of Birth: