Claimant's Social Security Number

Appointed Representative's Rep ID

Z	M	9	J	P	X	5	9	Z	H

Claimant's Appointment of a Representative

Section 1 - Claimant's Information

Social Security Number

First Name | **Initial** | **Last Name**

Mailing Address

City | **State** | **ZIP/Postal Code** | **Country - if outside the U.S.**

Phone Number

Country/Area Code | Phone Number

Alternate Phone Number (Optional)

Country/Area Code | Phone Number

Number Holder's Information *(Complete when applicable)*

My claim is based on another person's work or earnings (e.g., spouse or parent). This person's information is different from mine.

Number Holder's Social Security Number

First Name | **Initial** | **Last Name**

Section 2 - Disclosure *(Claimant Only)*

☒ By selecting this box, I, the claimant listed in Section 1, whose signature appears in Section 8, authorize SSA to release information in relation to my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g., clerks, assistants), partners, or parties under contractual arrangements for or with my representative. *(The appointed representative's partners, associates, delegates and designees must be prepared to provide information in order to be authenticated.)*

Section 3 - Principal Representative *(Claimant only – Complete when applicable)*

I have appointed before, or appoint now, more than one representative. I ask SSA to make contacts or send notices to this individual. My principal representative is:

Name Alexander A. Sioutis Esq.

Claimant's Social Security Number

			-			-				

Appointed Representative's Rep ID

Z	M	9	J	P	X	5	9	Z	H

Section 4 - Representative's Information *(Claimant and Representative)*

Representatives who are eligible and seek direct payment of their fee must register and receive a Rep ID before the appointment. For more information about registration visit us on-line at www.socialsecurity.gov/ar, contact us at 1-800-772-1213 (TTY 1-800-325-0778), or visit your local Social Security office.

Representative's Rep ID

Z	M	9	J	P	X	5	9	Z	H

First Name	Initial	Last Name
Alexander	A	Sioutis

Mailing Address

255 Great Valley Pkwy. Ste.150

City	State	ZIP/Postal Code	Country - if outside the U.S.
Malvern	PA	19355	

Phone Number		Alternate Phone Number (Optional)	
866	350-7229		
Country/Area Code	Phone Number	Country/Area Code	Phone Number

Section 5 - Representative's Status, Affiliations, and Certifications *(Representative Only)*

Representative's Status Part A - Type of Representative (Representatives have a duty to keep their information current)

☒ I am an attorney *(SSA regulation states that an attorney is someone in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)*

☐ I am a non-attorney eligible for direct payment *(SSA law requires that non-attorneys meet certain criteria to qualify for direct payment. Refer to our website at www.ssa.gov/representation for criteria).*

☐ I am a non-attorney not eligible for direct payment.

Representative's Status Part B - Disqualification

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice law.

☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency.

☐ Yes ☒ No

Claimant's Social Security Number: [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Appointed Representative's Rep ID: Z M 9 J P X 5 9 Z H

Section 5 - Continued *(Representative Only)*

Affiliation Information

If you are representing the claimant(s) as a partner or employee of a business entity, firm or other organization you may provide your Employer Identification Number (EIN) here, if one exists for tax purposes. This number is not your Social Security Number (SSN). This is your employer's tax identification number. (*Do not complete this section if you do not qualify for direct payment.*)

EIN 47 - 3375433

Organization's Name (Enter the full name of the business, entity, firm or organization with which you want to be affiliated while representing this claim)

Catwig LLC dba Victory Disability

Representative's Business Address (if different than mailing address)

City	**State**	**ZIP/Postal Code**

Country - if outside the U.S.

Representative's Certification

I accept this appointment and certify the following:

- I understand and agree that I will comply with SSA's laws and rules on the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives; I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies.
- I understand that if I fail to comply with any of SSA's laws and rules I may be suspended or disqualified as a representative before SSA.
- I will not disclose any information to any unauthorized party without the claimant's specific written consent.
- I am not currently suspended or prohibited, for any reason, from practicing before the Social Security Administration.
- I am not disqualified from representing the claimant as a current or former officer or employee of the United States.
- I accept appointment as the representative for the claimant named in Section 2 of this form in connection with the claims and asserted rights described in Section 6 of this form.
- I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original.
- I declare under penalty of perjury that I have examined all of the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

If I intend to seek direct payment of the authorized fee on this claim -

- I have registered for and obtained a Rep ID, and my registration information is up-to-date.
- I have provided up-to-date information on my registration concerning whether I have been suspended or prohibited from practice before SSA or any other Federal program or agency, disbarred or suspended by a court or bar, and convicted of a violation under Section 206 or 1631(d) of the Social Security Act.

I CERTIFY TO ALL OF THE ABOVE AAS *(Representative's Initials)*

Claimant's Social Security Number	Appointed Representative's Rep ID
	Z M 9 J P X 5 9 Z H

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 2 (RSDI), Title 16 (SSI), Title 18 (Medicare Coverage), and Title 8 (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (*Check all that apply*)

- ☒ Claim/Appeal for Title 2 Disability Benefits
- ☒ Claim/Appeal for Title 16
- ☒ Concurrent Title 2 and Title 16
- ☒ Claim/Appeal for Retirement Benefits
- ☒ Claim/Appeal for Title 18 (Medicare), 8 (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 *(Representative 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 ☐☐☐-☐☐-☐☐☐☐

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 2 (RSDI), Title 16 (SSI), Title 18 (Medicare Coverage), and Title 8 (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (*Check all that apply*)

☒ Claim/Appeal for Title 2 Disability Benefits

☒ Claim/Appeal for Title 16

☒ Concurrent Title 2 and Title 16

☒ Claim/Appeal for Retirement Benefits

☒ Claim/Appeal for Title 18 (Medicare), 8 (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 *(Representative 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**

Fee Agreement for Representation Before the Social Security Administration

General Information

You **can** use this form to file an agreement between you and your representative(s) to seek our authorization of the fee for services your representative(s) will provide before us. Section 206 of the Social Security Act limits the fee we authorize under a fee agreement to 25 percent of your past-due (retroactive) benefits or a maximum dollar amount we set, whichever is less. As of 11/30/2022, the maximum fee amount is $7,200. Your dependents or auxiliary beneficiaries who do not have their own representation will also be liable for a fee. This form does not limit you and your representative(s) from agreeing to any additional terms unrelated to the fee. Requesting, receiving, or keeping a fee in excess of the legal limit or in excess of what we authorize is unlawful and may lead to sanctions for your representative(s).

Representative's Information

Representative's Rep ID

Z	M	9	J	P	X	5	9	Z	H

First Name	Initial	Last Name
Alexander	A	Sioutis

Mailing Address
255 Great Valley Pkwy. Ste 150.

City	State	ZIP/Postal Code
Malvern	PA	19355

Phone Number		Alternate Phone Number (Optional)	
866	350-7229		
Country/Area Code	Phone Number	Country/Area Code	Phone Number

Claimant's Information

Claimant's Social Security Number

			–			–				

First Name	Initial	Last Name

Mailing Address

City	State	ZIP/Postal Code

Phone Number		Alternate Phone Number (Optional)	
Country/Area Code	Phone Number	Country/Area Code	Phone Number

Claimant's Social Security Number	Representative's Rep ID
	Z M 9 J P X 5 9 Z H

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 based 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. 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 _____

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
SSN	Birthday *(mm/dd/yy)*

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 to :**
   - 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 identify 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 international 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 SSA's 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

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(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:*

SIGN ▶	**IF** needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**
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 information 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.

Claimant/Patient:_____

AUTHORIZATION

I hereby authorize use or disclosure of protected health information, employment information, or other personal information about me as described below for Social Security purposes.

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:_____

2. The following person or class of persons may receive disclosure of protected health information about me:

Victory Disability, LLC
255 Great Valley Pkwy. Ste 150
Malvern, PA 19355
(P) 866-350-7229
(F) 866-350-7229
hearings@victory-disability.com

3. The specific information that should be disclosed is: all medical and mental health records, including sensitive information .

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I hereby discharge the releasing facility, its agents and employees, from any and all liabilities, responsibilities, damages, and claims which might arise from the release of authorization herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter, or hospitalization, or make copies thereof in accordance with the policies of this facility.

6. l may revoke this authorization by notifying the facility in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. l understand that the entity to whom this authorization is furnished may not condition its treatment of me, or payment, on whether or not I sign the authorization.

7. This authorization expires on, _____, OR one year after the date signed below, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: Social Security Determination.

8. Purpose of Disclosure: Social Security Purposes

X_____ _____
Signature of Individual or Representative Date

_____ _____
Date of Birth Social Security Number

PART 8 - IMPORTANT INFORMATION - PLEASE READ CAREFULLY

33. 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 cancelling 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.

PART 9 - SIGNATURES

34. 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.

35. Your Signature (First name, middle initial, last name) (Write in ink.)	Date (Month, day, year)

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

WITNESSES

37. 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)

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

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.

SIGNATURE OF APPLICANT	Date (Month, Day, Year)
Signature (First name, middle initial, last name) (Write in ink)	Telephone Number(s) at which you may be contacted during the day. (Include the area code)

DIRECT DEPOSIT PAYMENT INFORMATION (FINANCIAL INSTITUTION)

Routing Transit Number	Account Number	☐ Checking ☐ Savings	☐ Enroll in Direct Express ☐ Direct Deposit Refused

Applicant's Mailing Address *(Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)*

City and State	ZIP Code	County *(if any)* in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

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)*