THE LAW OFFICES OF
Gregory K. Kornegay
ATTORNEY AT LAW

Telephone: (910) 763-5757 **Toll Free: 1-866-579-5757** **Fax: (910) 763-5677**

Dear Client:

The purpose of this letter is to confirm that I, *Gregory K. Kornegay,* will represent you with regard to your Social Security claim. Thank you for selecting my law practice. **Please notify us of any changes in your medical condition, address or telephone number**. The following steps should be followed in regards to representation:

1. **Sign to the right of each red "X"** on the attached documents;

2. **Complete the Disability Report-Appeal Form as thoroughly as possible**. PLEASE READ AND FOLLOW THE INSTRUCTIONS CAREFULLY;

3. **Find the last correspondence you received from the Social Security Administration** or any of its offices; and

4. **SEND THESE ITEMS TO US AT:**

MAIL:
Gregory Kornegay
P.O. Box 900
Wilmington, N.C. 28402; or

FAX: (910) 763-5677; or

EMAIL: gkornegay@aol.com

Sincerely,

GREGORY K. KORNEGAY

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

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

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, _____
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title 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 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 _____
(Name of Principal Representative)

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

Part II ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

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	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part III FEE ARRANGEMENT

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

☐ **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 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 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 206 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 for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

FEE CONTRACT

I hereby retain Gregory K. Kornegay, Attorney At Law, to represent me in my claim for Social Security benefits. **There will be no fee unless I get Social Security benefits.**

If I do get Social Security benefits, **THE FEE WILL BE ONE-QUARTER (25%) OF MY BACK BENEFITS OR $6,000.00, WHICHEVER IS LESS.** These back benefits include all back benefits going to me and my family under both regular Social Security (Title II) and Supplemental Security Income (Title XVI). Back benefits also include any interim benefits paid to me and my family before getting a final decision on my case.

I agree to let my attorney know as soon as I get any money from Social Security.

I understand that I will have to directly pay the costs of any medical and/or vocational examinations needed to get evidence for my case, but my attorney will not schedule me for an examination unless I agree to it. I will have to reimburse my attorney for the costs of copying my medical records as needed. My attorney will pay all other costs of representation.

This attorney's fee contract covers only fees for representation before the Social Security Administration up thru the Hearing Level. If Social Security denies my claim and I want to appeal my case to the Appeals Council or Federal Court, my attorney and I will have to make a new agreement concerning attorney's fees for that representation.

This the _____ day of _____, 20_____.

X_____

CLIENT

_____

Gregory K. Kornegay

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.

DISABILITY REPORT - APPEAL - Form SSA-3441-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

We will use the information that you give us on this form to update your disability report information for your appeal. We will use the form to update your disability information **since you last completed a disability report.** Please complete as much of the form as you can. If you need help, your interviewer will help you finish it. If you have an appointment for an interview by telephone, have the form ready to discuss with us when we call you. If you have an appointment for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so. If you have access to the Internet, you may access the Disability Report Form - Appeal instructions at http://www.ssa.gov/online/ssa-3441.html.

If you are filling out the form for someone else, please provide information about him or her. When a question refers to "you," "your," or the "Disabled Person," it refers to the person who is applying for or has been entitled to disability benefits.

HOW TO COMPLETE THIS FORM

- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 3, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/OTHER/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THIS FORM.** However, you can get help from other people, like a friend or family member.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10 - REMARKS on Page 7, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records or copies of prescriptions at home, send them to our office with your completed form or, if you are having an interview in our office, bring them and any medicine containers with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of your medical sources, you may be able to get that information from the telephone book, medical bills, prescriptions, or prescription containers.

The Privacy Act

Sections 205(a), 223(d), and 1631(e)(1) of the Social Security Act authorize us to collect the information on this form. We will use the information you provide on this form to make a decision on your claim or case. Your response to this request is voluntary. However, failure to provide all or part of the information could prevent us from making an accurate and timely decision on your claim or case.

We rarely use the information you supply for any purpose other than for determining your living arrangements. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following: (1) to enable a third party or an agency to assist Social Security in establishing rights to Special Veterans Benefits; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Department of Veterans Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and (4) to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available online at www.socialsecurity.gov or at any local Social Security office.

The Paperwork Reduction Act

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 45 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov**. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)**. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form***.

AFTER COMPLETING THIS FORM, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

DISABILITY REPORT - APPEAL

For SSA Use Only
Do not write in this box.

Individual is filing:

Related SSN _____

☐ **Reconsideration**

Number Holder _____

☐ **Request for Review by Federal Reviewing Official**

Date of Last Disability Report _____

☐ **Reconsideration for Disability Cessation**

☐ **Request for ALJ Hearing**

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

A. NAME *(First, Middle Initial, Last)*

B. SOCIAL SECURITY NUMBER

C. DAYTIME TELEPHONE NUMBER *(If you do not have a number where we can reach you, give us a daytime number where we can leave a message.)*

_____ _____ ☐ Your Number ☐ Message Number ☐ None

Area Code *Number*

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim or case.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ _____ _____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Number*

SECTION 2 - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

A. Has there been any change (for better or worse) in your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

_____

_____

_____

Approximate date the changes occurred:

Month	Day	Year

B. Do you have any new physical or mental limitations as a result of your illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

_____

_____

_____

Approximate date the changes occurred:

Month	Day	Year

C. Do you have any new illnesses, injuries, or conditions **since you last completed a disability report?** ☐ Yes ☐ No

If "**Yes**," please describe in detail:

Approximate date the changes occurred:

Month	Day	Year

If you need more space, use Section 10 - REMARKS.

SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Since you last completed a disability report, have you seen or will you see a **doctor/hospital/clinic** or anyone else for the illnesses, injuries, or conditions that limit your ability to work? ☐ Yes ☐ No

B. Since you last completed a disability report, have you seen or will you see a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ Yes ☐ No

C. List **other names** you have used on your medical records.

If you answered "NO" to both A and B, go to Section 4 - MEDICATIONS.

Tell us who may have medical records or other information about your illnesses, injuries, or conditions **since you last completed a disability report.**

D. List each DOCTOR/HMO/THERAPIST/OTHER. Include your **next appointment.**

1.

NAME			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** VISIT
PHONE *Area Code* *Phone Number*		**PATIENT ID #** (If known)	NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** DID YOU RECEIVE?			

2.

NAME			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** VISIT
PHONE Area Code / Phone Number	**PATIENT ID #** (If known)		NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** DID YOU RECEIVE?			

If you need more space, use Section 10 - REMARKS.

E . List each HOSPITAL/CLINIC. Include your **next appointment.**

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE Area Code / Phone Number			☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Section 10 - REMARKS.

F. Since you last completed a disability report, does **anyone else have medical records or information** about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else? ☐ Yes ☐ No

If "**YES**," complete information below:

NAME			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** VISIT
PHONE *Area Code* *Phone Number*			NEXT **APPOINTMENT**
CLAIM NUMBER (if any)			
REASONS FOR VISITS			

If you need more space, use Section 10 - REMARKS.

SECTION 4 - MEDICATIONS

Are you currently taking any **medications** for your illnesses, injuries or conditions? ☐ Yes ☐ No

If "**YES**," please tell us the following: (*Look at your medicine containers, if necessary.*)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Section 10 - REMARKS.

SECTION 5 - TESTS

Since you last completed a disability report, have you had any **medical tests** for illnesses, injuries, or conditions or do you have any such tests scheduled? ☐ Yes ☐ No

If "**YES**," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN WAS/WILL TEST BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY -- Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY -- Name of body part _____			
MRI/CT SCAN -- Name of body part _____			

If you need more space, use Section 10 - REMARKS.

SECTION 6 - UPDATED WORK INFORMATION

Have you worked **since you last completed a disability report?** ☐ Yes ☐ No

If **"YES,"** you will be asked to give details on a separate form.

SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

A. How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

B. What changes have occurred in your daily activities **since you last completed a disability report?**

If none, show "**NONE**."

If you need more space, use Section 10 - REMARKS.

SECTION 8 - EDUCATION/TRAINING INFORMATION

Have you completed any type of **special job training, trade or vocational school since you last completed a disability report?** ☐ Yes ☐ No

If "**YES**," describe what type: _____

Approximate date completed: _____

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OTHER SUPPORT SERVICES INFORMATION, OR INDIVIDUALIZED EDUCATION PROGRAM

Since you last completed a disability report, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support;
- an individualized education program through an educational institution (if a student age 18-21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work? ☐ Yes ☐ No

If "**YES**," complete the following information:

NAME OF ORGANIZATION OR SCHOOL _____

NAME OF COUNSELOR OR INSTRUCTOR _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box, or Rural Route)

_____

City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES, TESTS, OR EVALUATIONS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, classes, etc.)

SECTION 10 - REMARKS

Use this section for any additional information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to go to the next page and complete the blocks there.

SECTION 10 - REMARKS

Name of person completing this form if other than the disabled person *(Please print)*	**Date Form Completed** *(Month, day, year)*
E-Mail Address of person completing this form *(optional)*	

If the person completing this form is other than the disabled person or the person identified in Section 1. Item D., please complete the following information.

Relationship to Disabled Person	**Daytime Telephone Number**
Address *(Number and street)* **City**	**State** **ZIP**