WILBORN LAW OFFICE, P.C.
TIM WILBORN, ATTORNEY AT LAW

Practice Limited To Social Security And SSI Disability Matters

P.O. Box 370578
Las Vegas, Nevada 89137
Telephone: (702) 240-0184
Facsimile: (503) 926-9133

Federal Court Representation Licensed Only In Oregon

Explanation of Contingent Fee Agreement

This is an explanation of your contingent fee agreement. Please read and sign this statement *before* signing the contingent fee agreement. The contingent fee agreement says:

1. We agree to handle your case.
2. If we handle your case to completion and do not establish your benefit entitlement or eligibility, or we do not recover any money or benefit for you, you do not have to pay us for our services.
3. If we handle your case to completion and establish your benefit entitlement or eligibility, or we do recover some money or benefit for you, you must pay us for our services. Our fee will be a percentage of what we recover for you. The percentage is set forth in our contingent fee agreement. Our agreement may also state that the contingent fee will not be smaller than a set dollar amount, or that the contingent fee will not be larger than a set dollar amount, or both. These dollar amounts, if any, are set forth in the agreement.
4. If we advance money for filing fees, doctors' reports, vocational reports, copy costs, postage charges, telephone charges, or any other expenses on your behalf, you must repay us for those costs/expenses whether the case is won or whether it is lost.
5. You may cancel the contingent fee agreement by notifying us in writing within 24 hours after you sign it.
6. If you cancel the agreement within the 24-hour period, you will have no obligation to us. If our services are terminated after the 24-hour period, we may have a claim against you for services provided up to the time of termination.

Explanation of Copy Charges and File Retention Policy

The file which the attorneys maintain shall be *the attorneys'* copy of the file. The client is encouraged to keep copies of all documents *before* providing any documents to the attorneys. The attorneys may charge for copies of documents provided to the client. The attorneys normally will keep the file for at least five years after the case is closed. The attorneys may be required to retain closed files for a certain period of time. After that time has expired, the attorneys will destroy the file, and by signing below, the client authorizes the attorneys to destroy the file at the appropriate time *without* further notice to the client. The client should request all desired copies from the file within six months after the work on the case is completed. Upon request, the attorneys normally will provide the exhibit file to the client with the understanding that it will be the client's responsibility to safeguard that file, and that the attorneys will not be able to provide another copy in the event the original is lost.

I have read, do understand, and have accepted the foregoing explanations before I signed a contingent fee agreement with Wilborn Law Office, P.C.

_____ _____
Client's Signature Date

_____
Client's Name (print or type)

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SOCIAL SECURITY EMPLOYMENT AGREEMENT

I, _____, hereby employ the attorneys of Wilborn Law Office, P.C., to represent me in my claim before the Social Security Administration, and, if necessary and appropriate, in federal court. I understand my attorneys have not promised to win my case but will do their best to help me.

My attorneys are authorized to file documents and act for me in all respects. I agree that another attorney may be employed or associated as co-counsel by Wilborn Law Office, P.C., and that any such attorney may assist in my representation in this matter, under the terms of the fee agreement which follows. If Wilborn Law Office, P.C., is succeeded by a new business entity, that business entity shall take over all rights and responsibilities under this contract. My attorneys are authorized to disclose information in my file to other attorneys, representatives, or government officials with whom my attorneys deem it appropriate to confer regarding matters related to my case. My attorneys are authorized to contact the Tax Offset Program Help Desk on my behalf to inquire about the existence and amount of any federally-offsettable debt. If my attorneys procure a remand for another hearing, I understand that a different attorney may handle my case from that point forward, and I authorize that attorney to contact me directly, without my first having initiated contact with that attorney. I authorize my attorneys to divide the work on my case with one or more additional attorneys, and to share fees among attorneys in a manner which shall be left to the sole discretion of the attorneys, so long as such fee sharing does not increase the total fee owed by me beyond the amount specified in this contract. I understand the scope of my attorneys' practice currently is focused on post-hearing appeals, and if my attorneys obtain an order sending my case back for another hearing, my attorneys probably will not represent me at that hearing, but instead will attempt to refer my case to a different representative whose practice includes hearing-level representation.

CLIENT'S DUTY TO ADVISE OF CHANGED CIRCUMSTANCES

I WILL INFORM MY ATTORNEYS if I have a change of address or phone number; if I have a significant change in my medical condition; if I work or file another claim; if I receive any phone calls or correspondence from Social Security; or if other circumstances arise which may affect my claim.

WITHDRAWAL FROM CASE BY ATTORNEYS / ABANDONMENT OF CLAIM

I agree that my attorneys may withdraw from this case at any time if they believe my claim is not meritorious; or if I fail to cooperate with them. I agree that if I fail to cooperate with my attorneys, they may withdraw from further representation after they have given me reasonable notice and an opportunity to cooperate. If I move and fail to advise my attorneys of my new address, my attorneys may withdraw from my claim by sending a letter to my last known address advising me of their withdrawal, and such withdrawal shall relieve my attorneys from all further obligations related to my case *whether or not I actually receive the letter*. I agree not to discharge my attorneys without cause and not to abandon this claim except upon advice of counsel. I may terminate this agreement only by signing a notarized notice advising the attorneys that I am terminating the agreement.

SCOPE AND DURATION OF REPRESENTATION

The scope of representation of this agreement is limited to the continuing appeal of one specific adverse determination or decision, made by the Social Security Administration, in my claim for Social Security Disability and/or SSI Disability benefits. My attorneys have NOT agreed to represent or advise me with regard to any other claim. I acknowledge that there may be other benefits to which I may be entitled, depending upon my individual circumstances, and that it is my responsibility (and NOT the responsibility of the attorneys) to investigate and pursue any eligibility for such benefits. Such benefits may include food stamps, retirement benefits, union benefits, medical assistance programs, workers' compensation benefits, personal injury actions, railroad benefits, and any number of other government or private means of remuneration or assistance.

The representation herein may terminate, at the sole discretion of the attorneys, at (or any time after) the time a decision is issued by a court or by the Social Security Administration. The attorneys *may* choose to assist me with such "follow up" issues as monitoring receipt of retroactive benefits.

EXPENSE DEPOSIT

If requested, I will give my attorneys an expense deposit of $_____ ($50.00 if blank) to draw upon as expenses are incurred. I will give additional expense deposits as necessary to maintain the expense deposit at the $50.00 level. My attorneys will refund to me any expense deposit which remains at the end of my case. My attorneys may apply any expense deposit toward any unpaid fees, and any fees toward unpaid expenses.

OUT-OF-POCKET EXPENSES

I agree to re-pay to my attorneys all out-of-pocket costs and expenses incurred by my attorneys in pursuing this claim ***even if my attorneys are not successful in this representation***. Examples of expenses include but are not limited to the cost of medical examinations; doctors' reports; medical records; telephone charges; postage charges; charges for photocopies; and court filing and appeal fees. **I understand that expenses are separate from attorneys' fees. Expenses *will not* be included in any attorneys' fees awarded and must be paid separately.**

DEFINITION OF PAST-DUE BENEFITS

For purposes of calculating the amount of any attorneys' fees due or payable under this contract, the term "past-due benefits" shall have the definition given it by applicable statute(s) and/or validly promulgated Social Security regulations, and shall include benefits payable both to the disabled claimant and to all other beneficiaries who become eligible for benefits as a result of the disabled claimant's disability.

CONTINGENT ATTORNEYS' FEE FOR REPRESENTATION BEFORE THE AGENCY

I agree that if a favorable decision is issued by the Social Security Administration or by a court, I will pay my attorneys, **for representation before the agency**, a fee equal to the **LESSER** of **25%** of the past-due benefits resulting from my claim or claims **OR** the amount set by the agency under 42 U.S.C. § 406(a)(2)(A) (which was **$6,000.00** at the time this contract was signed, but which is subject to upward adjustment for inflation).

CONTINGENT FEDERAL COURT ATTORNEYS' FEE

I and my attorneys agree that if it is necessary to appeal this case to court, the attorneys' fee for representation before the court is separate from and in addition to any fee for representation before the agency. The court attorneys' fee for representation in my disability claim(s) shall be the **GREATER** of the following:

1) **25 (twenty-five) percent** of the past-due benefits resulting from my claim or claims (which I understand may exceed $1,000.00 per hour), **OR**
2) The amount of any award ordered pursuant to the Equal Access To Justice Act (EAJA) for the hours expended in pursuit of my disability claim(s).

If EAJA fees are awarded for hours my attorneys expend in pursuit of EAJA fees, my attorneys shall be entitled to retain those EAJA fees in addition to any fees awarded for hours expended in pursuit of my disability claim(s), to the fullest extent allowed by law.

To the fullest extent permissible under law, I assign to my attorneys the right to receive any EAJA award(s) or check(s) in payment of award(s) directly in the attorneys' names. My attorneys shall have the beneficial interest in the EAJA fee award. See 31 C.F.R. § 285(e)(5). If the government issues checks in my (the claimant's) name for fees, costs, or expenses under any law which shifts to the government the responsibility for making such payments, I authorize my attorneys to sign and deposit such checks on my behalf, and immediately to take any amounts to which the attorneys are entitled under this contract. I authorize my attorneys to request that the court award beneficial interest in any costs, expenses, and/or EAJA fees to my attorneys, and that the government authority responsible for payment of such award(s) pay any and all amounts awarded directly to my attorneys. If any portion of a fee awarded in my case is taken by the federal government to pay any debt I owe, I agree immediately to reimburse my attorneys for the amount of the fee taken in payment of my debt.

I understand and agree that my attorneys may receive EAJA fees for obtaining a court order remanding my case for further administrative proceedings, even if I am not ultimately found disabled after such further administrative proceedings. In order for my attorneys to become entitled to federal court fees paid out of my retroactive benefits, however, there must be a finding of disability (*made either by the court or by the Social Security Administration after remand from the court*) followed by an award of benefits to me and/or to other beneficiaries in association with my claim(s). If the Social Security Administration sends to my attorney a court fee authorized under 42 U.S.C. § 406(b) which is larger than the fee my attorney is entitled to keep after offsetting the EAJA fee previously received by my attorney as payment for the same work, I instruct my attorney, on my behalf and as a convenience to me, to forward to my administrative attorney (if any) up to but not in excess of the amount of any then-unpaid fee due (or pending agency approval) from me for representation before the agency.

The total fee for both the Title II (SSD) and Title XVI (SSI) claims may not exceed the amount(s) stated above. I MAY CANCEL THIS AGREEMENT BY NOTIFYING WILBORN LAW OFFICE, P.C., IN WRITING BY THE END OF THE NEXT BUSINESS DAY AFTER I HAVE SIGNED IT. I have read this agreement or had it explained to me before I signed it and I have received/kept a signed copy of it.

CLIENT'S SIGNATURE Date

ATTORNEY AT LAW Date

SSN: _____

Questionnaire for Court Appeal

Name of Claimant: _____

Date of Birth: _____/_____/_____

Phone Number: _____ Message Number: _____

Mailing Address: _____

E-Mail Address: _____

List Your Children Who Were Under Age 19 When You Became Disabled:

Name: _____; SSN: _____

Name: _____; SSN: _____

Name: _____; SSN: _____

Are you currently employed?

___ **YES, I am currently employed.** My take-home pay is $_____ per month, and I work for this employer:

Name of current employer: _____

Employer's address: _____

___ **NO, I am not currently employed.** I last worked for the following employer, and earned the amount indicated:

Date of last employment (estimate if necessary): _____

Amount of most recent monthly take-home pay: $_____

Name of most recent employer: _____

Most recent employer's address: _____

Do you owe past-due child support, do you owe any debt to the government including unpaid taxes, or do you have any delinquent student loans? If yes, describe type and amount of debt:

1. _____
2. _____
3. _____

TIM WILBORN, ATTORNEY AT LAW — OSB # 944644
WILBORN LAW OFFICE, P.C.
tim@wilbornlaw.com
P.O. Box 370578
Las Vegas, NV 89137
Voice: (702) 240-0184
Fax: (503) 926-9133
Attorney for Plaintiff

UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

_____, Case No.

Plaintiff,

vs.

CERTIFICATE OF NET WORTH

COMMISSIONER OF SOCIAL SECURITY,

Defendant.

I, the undersigned disability claimant, am the plaintiff in the above-captioned matter. At the time I filed this civil action, my financial net worth was less than $2,000,000.00 (two million dollars). This certificate is made in lieu of Affidavit pursuant to 28 U.S.C. § 1746. I certify under penalty of perjury that the foregoing is true and correct.

DATED this _____ [day] of _____ [month], 201____ [year].

_____

-- Plaintiff

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize and request you to release to my attorney, Tim Wilborn, or his representative, all information and records requested concerning my mental, physical, financial, or other condition, including drug and/or psychiatric treatment. You are also authorized to release, copy, or discuss any social, financial, employment, or other information about me to or with my attorney or his representative.

This authorization shall continue in force until I revoke it in writing. A photocopy or facsimile of this authorization shall serve the same as the original, and this authorization shall be valid for all records existing prior to and compiled subsequent to its execution.

↙

AUTHORIZING SIGNATURE: _____ DATE:_____

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize and request you to release to my attorney, Tim Wilborn, or his representative, all information and records requested concerning my mental, physical, financial, or other condition, including drug and/or psychiatric treatment. You are also authorized to release, copy, or discuss any social, financial, employment, or other information about me to or with my attorney or his representative.

This authorization shall continue in force until I revoke it in writing. A photocopy or facsimile of this authorization shall serve the same as the original, and this authorization shall be valid for all records existing prior to and compiled subsequent to its execution.

↙

AUTHORIZING SIGNATURE: _____ DATE:_____

AUTHORIZATION FOR RELEASE OF CONTACT INFORMATION

I, _____, hereby authorize the State of Oregon and all of its employees to disclose to my attorney my most recent contact information, specifically to include any and all contact information maintained by the State in connection with the administration of any benefits program or any other records the State may have regarding my location, or which might lead to discerning my location. This authorization applies to physical or postal addresses, phone numbers, e-mail addresses, and contact information via all private and public parties who may know how to locate me.

This authorization shall continue in force until I revoke it in writing. A photocopy or facsimile of this authorization shall serve the same as the original, and this authorization shall be valid for all records existing prior to and compiled subsequent to its execution.

↙

AUTHORIZING SIGNATURE: _____ DATE:_____

NOTE: THIS PAGE MUST BE NOTARIZED.
Do not sign this page before taking it to a notary.

LIMITED POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that I, the undersigned disability claimant, do hereby make, constitute and appoint Tim Wilborn my true and lawful Attorney, for me and in my name, place and stead and for my use and benefit to:

1) Contact the Financial Management Service of the Department of the Treasury to inquire about the existence, nature, and amount of any federally-offsettable debt. If any federally-offsettable debt is found to exist, then I agree that Tim Wilborn may immediately cancel the Social Security Employment Agreement contract, withdraw from my case, and decline to represent me in any legal capacity.

2) Endorse all checks made out to me regarding any settlement fees, costs, or expenses pursuant to the Equal Access To Justice Act (EAJA) or any other law in the matter of my claim against the Commissioner of Social Security.

3) Apply to the government and/or court to have any EAJA awards and/or EAJA settlement checks made payable directly to Tim Wilborn and sent directly to Tim Wilborn's address.

4) Use my full Social Security Number on all documents related to my claim, no matter to whom delivered, faxed, electronically sent, or mailed.

I hereby grant to my attorney full power and authority to perform the above actions as well as additional actions which may be necessary in order to accomplish the above actions, as fully, to all intents and purposes, as I might or could do if personally present, hereby ratifying and confirming all that my attorney shall lawfully do or cause to be done, by virtue hereof. In construing this instrument and where the context so requires, the singular includes the plural.

Dated this _____ [day] of _____ [month], 20____ [year].

Signature: _____
Printed Name:

State of _____, County of _____) ss.

Personally appeared before me the above named person, and acknowledged the foregoing instrument to be his/her voluntary act and deed.

Before (Name of Notary): _____
Notary Public of (State): _____
My commission expires (date): _____

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 CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this individual, TIM WILBORN
(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) ☐ Title VIII (SVB)

This individual 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 principal representative is:

_____
(Name of Principal Representative)

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

Part II REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, TIM WILBORN , 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 P.O. BOX 370578 LAS VEGAS, NV 89145	
Telephone Number (with Area Code) 702 240 0184	Fax Number (with Area Code) 503 926 9133	Date

Part III FEE ARRANGEMENT

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

☒ **I am 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.)*

☐ **I am 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.)*

☐ **I am 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 entity or government agency, 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.)*

☐ **I am 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