APPOINTMENT OF REPRESENTATIVE/ DESIGNATION OF HEALTHCARE SURROGATE FORM

NAME (Print Name)____ **HI Claim Number:**____________________

SECTION I

I appoint ____________________________________ to act as my representative in connection with my claim or asserted right under Titles XI, or XVIII of the Social Security Act. I authorize this person to make or give any request or notice; to present or to elicit evidence; to obtain information; and to receive any notice in connection with my claim wholly in my stead:

Signature (Beneficiary)____ Member Number:____________________

Address:____, Florida ________

Date:____________________ Telephone Number ( )____________________________

SECTION 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 or the Centers for Medicare and Medicaid Services: that I am not, as a current or former officer or employee of the United States, disqualified from acting as the claimants representative; and that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations referred to on the reverse side hereof. In the event that I decide not to charge or collect a fee for the representation I will notify the Social Security Administration and the Centers for Medicare & Medicaid Services (completion of Section III (optional) satisfies this requirement) I am a/an ____

(State Relationship to patient)

Signature(Representative)____ Date______________________

Address:____ Telephone: ( ) __________________

SECTION III DESIGNATION OF HEALTHCARE SURROGATE (POWER OF ATTORNEY FOR HEALTHCARE DECISIONS)

I, _________________________________, hereby appoint: Designee:______________________________________

Print Name of Member Print Name of Designee

To serve as my "agent" and to exercise the powers set forth below. In addition, in order to provide for succession in the event my agent cannot continue to serve, I hereby appoint the following person to serve as an alternate to my agent: Alternate Designee: ____ Telephone ( ) ______________________

Print Name of Alternate Designee

By this document I intend to create a Durable Power of Attorney for Health Care. If no agent designated in this document is available or able to serve, I request that my desires expressed in this document be given full force and effect as a written expression of intent under applicable law. I desire that my wishes as expressed herein be carried out through the authority given to my agent by this document despite any contrary feelings, beliefs or opinions of members of my family, relatives, friends or guardian of my estate.

My agent is further instructed that if I am unable to give an informed consent to a proposed medical treatment, my agent shall give, withhold or withdraw such consent for me based upon any treatment choices that I have expressed while competent, whether under the circumstances then my agent should make such choice for based upon what my agent believes to be in my best interest. Accordingly, my agent is authorized as follows:

A. Give, Withhold or Withdraw Consent for Medical Treatment: To give or withhold consent to any medical procedure(s), test or treatment, including surgery; to arrange for my hospitalization, convalescent care, hospice or home care; to summon paramedics or other emergency medical personnel and seek emergency treatment for me, as my agent shall deem appropriate; and under circumstances in which my agent determines that certain medical procedures, tests or treatments are no loner of benefit to me or, where the benefits are outweighed by the burdens imposed, to revoke, withdraw, modify or change consent to such procedures, tests and treatments, as well as hospitalization, convalescent care, hospice or home care which I or my agents may have previously allowed or consented to or which may have been implied due to emergency conditions. My agent's decisions should be guided by taking into account (1) the provisions of this document (2) any reliable evidence of preferences that I may have expressed on the subject, whether before or after the execution of this document (3) what my agent believes I would want done in the circumstance if I were able to express myself, and (4) any information given to my agent by the physician(s) treating me as to my medical diagnosis and prognosis, and the intrusiveness, pain, risks and side effects associated with the treatment.

APPOINTMENT OF REPRESENTATIVE/DESIGNATION OF HEALTHCARE SURROGATE FORM

B. Exercise and Protected My Rights: To apply for public benefits to defer the cost of healthcare and authorize for my transfer to or from a healthcare facility.

I further reaffirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I understand , should my judgment incapacitation or incompetence be reversed such that I am once again considered competent to make my own decisions, such decision will once again be mine. I understand that I may rescind this declaration at any time so long as I am judged to be competent and capable to make such judgments.

Additional Instructions:____

Do you have a Living Will Declaration? [ ] Yes [ ] No

Signature: ________________________________ Date________________

Witness #1________________________________ Date________________

Witness #2________________________________ Date________________

SECTION IV (Optional) WAIVER OF FEE OR DIRECT PAYMENT

(Note to Representative: You may use this portion of the form to waive a fee or to waive direct payment of the fee from withheld past-due benefits.) I waive my right to charge and collect a fee for representing________________________

Before the Social Security Administration or the Centers for Medicare & Medicaid Services.

SIGNATURE________________________________ DATE:________________

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SOCIAL SECURITY ADMINISTRATION

An attorney, or other representative, who wishes, to charge a fee for services rendered in connection with a claim before the Social Security Administration is required by law to obtain approval of the Fee from the Social Security Administration or the Centers for Medicare & Medicaid Services (section 206(a) and 1631(d)(2) of the Social Security Act; sections 404.1720 and 416.1520 of the Social Security Administration Regulations Nos. 4 and 16, respectively). If the representative wishes to waive a fee or to waive direct payment of the fee from the past due Social Security benefits, he may do so. Section III on the front of this form can be used for that purpose. The form SSA -1560-U4, Petition to obtain approval of a Fee for Representing a Beneficiary before the Social Security Administration, elicits the information required to be submitted in support of fee petitions. It should be completed by the representative after services are completed and the original and the third carbon copy of the SSA-1560-U4 filed with the office of the Social Security Administration or the Centers for Medicare & Medicaid Services which took the latest action on the claim. The representative is required to furnish the Claimants/Beneficiaries Copy of the SSA-1560-U4 petition to the claimant for whom the services were rendered. Social Security Administration approval of a fee is not required where the fee is for services ; (1)rendered in an official capacity such as that of legal guardian, committee, or similar court appointed office and the court has approved the fee in question, (2) in representing the beneficiary before a court of law, or (3) in representing the beneficiary in a claim for reimbursement of medical expenses exclusively handled by a private intermediary. Where a representative has rendered services in a claim before the Social Security Administration and a court of law, the regulations require that the amount of the fee to be charged, if any, for services performed before the Social Security Administration be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted. In t his connection a claim which has been remanded by a court to the Social Security Administration for further administrative proceedings is considered to be before the Social Security Administration after the remand by the court. AUTHORIZATION OF FEE The social security regulations contemplate that a representative will receive fair value for those services performed before the Social Security Administration on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the Social Security Administration or the Centers for Medicare & Medicaid Services considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the claim and the amount of the fee requested by the representative, when a fee is authorized, both the representative and the claimant are notified and allowed 30 days in which to request an administrative review in case of disagreement. CONFLICT OF INTEREST Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. **Please complete and mail this form to:**

1205 S.W. 37th Avenue 2nd Floor
Miami, Florida 33135