Application to Participate in the Eligible For Direct Payment Non-Attorney Representative Program

In this document, “you” means the non-attorney applicant. “Us,” “we” and “SSA” means the Social Security Administration.

General information about this form

The purpose of this form is to collect your information, which we will review and determine whether you qualify to take the examination, participate in the program, and act as an eligible for direct payment non-attorney (EDPNA). You must complete this application carefully and provide all supporting documentation as required. You must mail a completed and signed form to the administrator of the EDPNA program. You can find the administrator’s mailing address and any other information about the EDPNA program by going to our Representing Social Security Claimants website at http://www.ssa.gov/representation/.

Attorneys who have fees paid directly from their clients' past-due benefits pursuant to section 206 of the Social Security Act (the Act) are not required to take the examination. Attorneys who are suspended or disbarred by a State or Federal court or disqualified from appearing before a Federal agency or program are not eligible to receive direct payment and should not submit an application.

Application fee

The Commissioner may assess applicants a reasonable, non-refundable fee to cover the costs of administering the prerequisites process. We only accept checks from a U.S. financial institution and money orders. Visit http://www.ssa.gov/representation to find out where to pay this fee and other guidelines about this application fee.

If you fail the examination, or we find you ineligible to take the examination because you do not meet the educational requirement, you may reapply in any future application period, but must pay the full fee again. If we find you ineligible to take the exam because you failed the background check, you cannot reapply in any future application period.

Examination

You are required to pass an examination testing your knowledge of the relevant provisions of the Act and the most recent changes in Agency regulations and court decisions affecting Titles II and XVI of the Act. For more information about the details of the examination, visit http://www.ssa.gov/representation/.

Instructions for completing this form

This form is available in fillable PDF form during the application period at http://www.ssa.gov/representation/. If you are using a printed copy, type or print legibly using only a blue or black ink pen. Complete all sections. If you need to provide additional information, attach an supplementary page.

Section 1 – Applicant’s Information

Complete all the information, including your name, Social Security Number, date of birth and contact information.

Section 2 – Educational or Equivalent Professional Work Experience Information

Complete only the applicable information.

You must possess either a bachelor’s degree from an accredited U.S. postsecondary institution or a high school diploma or general equivalency diploma (GED) plus four years of relevant professional experience that we determine to be equivalent to a bachelor’s degree. You must meet these requirements prior to the date the application period begins. Relevant professional experience means training or work through which you demonstrate familiarity with medical reports and an ability to describe and assess mental or physical limitations or both. Such experience may be in the fields of: teaching, counseling or guidance, social work, personnel management, public employment service, nursing or other health care services. Professional work involving evaluating or adjudicating claims for benefits under Title II or Title XVI of the Act also qualifies as relevant professional experience.

You must send proof of your educational qualifications after you pass the examination. Failure to do so precludes you from establishing your eligibility to receive direct payment of fees. Visit http://www.ssa.gov/representation/ for types of acceptable proof.

Section 3 – Disqualification

Respond to all statements and provide relevant information as it applies.

Section 4 – Examination Location

We administer the examination(s) on a single day each year at designated locations across the country. We may cancel the examination(s) scheduled for any designated location if enrollment is insufficient. In that event, we will notify you at least 20 days prior to the examination date, so you can make appropriate travel arrangements to an alternate examination location. See http://www.ssa.gov/representation/ for a list of examination locations.

You must select a first and second choice for your preferred examination location when applicable. If you submit your application timely but do not select a second choice, we will return your applications as incomplete. We will send detailed information concerning the specific location of the examination site by mail to those applicants we deem eligible to sit for the examination.

Section 5 – Signatures

Read and initial the first two statements before signing the form below the perjury statement.

Section 6 – Criminal Background Check

Complete all fields. We use this information to ensure your fitness to practice before us. Visit http://www.ssa.gov/representation/ to review the requirements or our criminal background check.

Privacy Act Statement
Collection and Use of Personal Information

Section 206(e) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from determining your eligibility for direct payment.

We will use the information to determine your eligibility for direct payment. We may also share your information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, to assist us in efficiently administering our programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records; and

- To student volunteers, persons working under a personal services contract, and others who are not technically Federal employees, when they are performing work for us, as authorized by law, and they need access to information in our records in order to perform their assigned duties.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0325, entitled Appointed Representative File, as published in the Federal Register (FR) on October 8, 2009, at 74 FR 51940. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

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 Budget control number. We estimate that it will take 45 minutes to read the instructions, gather the facts, and answer the questions. Send only comments relating to 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.***

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Section 1 - Applicant's Information

First Name	Full Middle Name	Last Name	Suffix

Other Names Used (with reason)

SSN	Date of Birth (mm/dd/yyyy)

Citizenship status

☐ U.S. Citizen ☐ Naturalized Citizen

Mailing Address

City	State	Zip Code

Preferred Email Address	Alternate Email Address

Phone Number	Alternate Phone Number	Work Phone Number
Area Code Phone Number	Area Code Phone Number	Area Code Phone Number

Section 2 - Educational or Equivalent Professional Work Experience Information

U.S. postsecondary degree received

☐ Doctorate Degree ☐ Graduate Degree ☐ Bachelor's Degree

Name of U.S. College or University	City	State

Attended from Date (mm/yyyy)	Attended to Date (mm/yyyy)	Degree granted
		☐ Yes ☐ No

High School or GED certificate received *(not required with postsecondary degree)*	Date awarded (mm/yyyy)
☐ High School Diploma ☐ GED Certificate	

City	State

Section 2 - Educational or Equivalent Professional Work Experience Information - Continued

Relevant professional experience *(not required with postsecondary degree)*

☐ SSA-related professional experience ☐ Other professional experience

Position/Title	From Date to Date (mm/yyyy)

Position Description

Name of Employer

Address of Employer

City	State	Zip Code

Name of Supervisor	Employer Phone Number
	Area Code Phone Number

Additional relevant professional experience *(not required with postsecondary degree)*

☐ SSA-related professional experience ☐ Other professional experience

Position/Title	From Date to Date (mm/yyyy)

Position Description

Name of Employer

Address of Employer

City	State	Zip Code

Name of Supervisor	Employer Phone Number
	Area Code Phone Number

Section 3 - Disqualification

I am now or have been disqualified, sanctioned or suspended from participating in any Federal program or appearing before the SSA or any other Federal Agency.	☐ Yes ☐ No

If Yes, provide Name of Program or Agency

Address of Program or Agency

City	State	Zip Code

Details of Disqualification, Sanction or Suspension

Date of Disqualification, Sanction or Suspension (mm/dd/yyyy)	Date of Reinstatement (mm/dd/yyyy)

I am now or have been disqualified, sanctioned or suspended from participating in any Federal program or appearing before the SSA or any other Federal Agency.	☐ Yes ☐ No

If Yes, provide Name of Program or Agency

Address of Program or Agency

City	State	Zip Code

Details of Disqualification, Sanction or Suspension

Date of Disqualification, Sanction or Suspension (mm/dd/yyyy)	Date of Reinstatement (mm/dd/yyyy)

I have fraudulently used or misused any Social Security Benefits	☐ Yes ☐ No	I have a judgment or lien assessed against me by a civil court for malpractice and/or fraud	☐ Yes ☐ No
I have a record for felony conviction	☐ Yes ☐ No	I have violated Social Security program rules (e.g., rules regarding disclosure of evidence or representative payee rules)	☐ Yes ☐ No

I have previously applied for the Social Security Administration Eligible for Direct payment Non-attorney Representative examination. (If you were previously denied because of a failed background check, you may not reapply again.) ☐ Yes ☐ No

Section 4 - Examination Location

If offered multiple examination locations, you must indicate your first two choices. You cannot select the same location twice.

First Choice	City	State
Second Choice	City	State

Describe any special accommodation(s) you will need at the examination location. Please note that you must provide supporting documentation from a professional qualified to determine your condition along with your application to the address indicated on the Representing Social Security Claimants Website at http://www.ssa.gov/representation/.

I certify that I understand that I must provide written documentation to support my request for special accommodations along with this application.

Initials

Section 5 - Acknowledgments and Signature

If I cannot substantiate the statements made in my application or it is determined that the information I entered is incorrect, I understand that I may be determined ineligible to sit for the examination or to receive direct payment of fees.	Initials
The application fee is generally non-refundable.	Initials

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	Date (mm/dd/yyyy)

Section 6 - Criminal Background Information

I authorize SSA to conduct a criminal background check so SSA may secure any criminal history information pertaining to me that may be in the files of any Federal, State, or Local criminal justice agency. I authorize any Federal, State, or Local criminal justice agency to release to SSA any criminal history information pertaining to me that may be in the agency's files. I authorize SSA, and any of its agents, to disclose orally and in writing the results of this criminal background check to the business entity that manages the information for managing direct payment eligibility for non-attorney representatives.

I understand that the results of the criminal background check may be used by SSA to determine my eligibility to sit for the examination and receive direct payment, and may not otherwise be used except as authorized by law. In the event that SSA uses information from the criminal background check, in whole or in part, in making an adverse decision with regard to my eligibility to sit for the examination or to receive direct payment, I understand that SSA will provide me a copy of the report on the criminal background check submitted by SSA and a description in writing of my right to protest the decision to SSA.

I understand that submission of this authorization is voluntary. I also understand that failure to provide the authorization and information required to conduct a criminal background check will cause SSA to deny my application.

I understand that copies of this authorization that show my signature are as valid as the original, and that this authorization is valid for 6 months from the date signed.

First Name	Middle Name	Last Name

Date of Birth (mm/dd/yyyy)	Place of Birth	
SSN	**Sex**	**Race (optional)**

List of addresses for the last five years

Current address	City, State, Zip Code	From date (mm/yyyy) to present
Previous address	City, State, Zip Code	From date (mm/yyyy) to date (mm/yyyy)
Previous address	City, State, Zip Code	From date (mm/yyyy) to date (mm/yyyy)
Previous address	City, State, Zip Code	From date (mm/yyyy) to date (mm/yyyy)
Previous address	City, State, Zip Code	From date (mm/yyyy) to date (mm/yyyy)

Signature	Date (mm/dd/yyyy)	Daytime Phone Number
		Area Code Phone Number