DEPARTMENT OF
HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

Name (Print or Type)	H.I. CLAIM NUMBER

SECTION I - APPOINTMENT OF REPRESENTATIVE

I appoint this individual: **HMI HOME HEALTH Agency**

To act as my representative in connection with my claim or asserted right under Titles XI, or XVII of the Social Security Act. I authorize this individual 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)	ADDRESS
TELEPHONE NUMBER	DATE

SECTION II - ACCEPTANCE OF APPOINTMENT

I, HMI HOME HEALTH Agency, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration or the Health Care Financing Administration from acting as the claimant's 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 decided not to change or collect a fee for the representation, I will notify the Social Security Administration and the Health Care Financing Administration (completion of Section III optional, satisfies this requirement). I am a Home Health Agency.

1025 Vermont Avenue, NW
Washington, DC 20005

SIGNATURE (Representative)	ADDRESS
TELEPHONE NUMBER **(202) - 829 - 1111**	DATE

SECTION III (Optional) - WAIVER/ FEE OR DIRECT PAYMENT

(Not 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 Health Care Financing Administration.

SIGNATURE	DATE

(See important information on reverse)

FORM HCF- 1696 – U4 (10-84)