

APPLICATION FOR APPROVAL OF A REPRESENTATIVE'S FEE IN A BLACK LUNG CLAIM PROCEEDING CONDUCTED BY THE U.S. DEPARTMENT OF LABOR

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation



NOTE: No fee for services performed may be paid under this program unless the information prescribed by existing regulations is provided to this office. Disclosure of your Social Security Number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled.

OMB No. 1240-0011
Expires: 10/31/2023

1. In accordance with the provisions of the Black Lung Benefits Act, 30 U.S.C. 901 et seq., 33 U.S.C. 928 and the regulations of the U.S. Department of Labor governing the administration of such Act (20 CFR 725.365 et seq.) I the undersigned hereby make application for a representative's fee for my services rendered from _____ to _____ in the claim of: _____ (Client's Name – Last, First, Middle Initial)
 District Director Administrative Law Judge Benefits Review Board _____
 Other (Specify) _____

2. Miner's Name: **Carl Maynard**
 3. DOL's Case ID Number: **PI XXX-XX-3037 LM C**
CASE ID: BDYBC-2018150

4. Services Rendered (Use blank sheet of paper if additional space is needed)

(a) Date Rendered	(b) Itemize services rendered. (See reverse side for instructions)	(c) Professional Status of Person Who Performed the Service	(d) Usual Billing Rate Per Hour At Time of Services	(e) Time to Nearest ¼ Hour

TOTAL TIME EXPENDED ON CASE DURING PERIOD:

5. Miscellaneous Expenses **DOCUMENTED RECEIPTS MUST BE ATTACHED** (Use blank sheet of paper if additional space is needed)

(a) Date Rendered	(b) Itemize unreimbursed expenses incurred in connection with claim (See Reverse)	(c) Cost
		\$

TOTAL MISCELLANEOUS EXPENSES INCURRED

6. **Total Fee Requested** (Amount of fee requested for services rendered and expenses incurred during the period designated in block 1 and itemized in blocks 4 and 5):
 \$ _____.

7. Explain on a separate sheet the nature and extent of any unusual circumstances or any other relevant data which should be considered in approving your fee. Note: As stated in 20 CFR 725.365, no lay representative is entitled to a lien against the award.	8. Did you or your firm receive or request any fee for services rendered to the claimant in any claim for pneumoconiosis (black lung) benefits before any state or federal agency? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, show amount: \$ _____.	9. Did you request monies from this claimant to place in an escrow account or to use as an expense advances? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, show amount: \$ _____ and itemize on separate sheet (See Reverse).
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Certification: I certify that the fees and expenses listed in blocks 4 through 9 constitute the complete claim for representing this client during the period and before the adjudication officer indicated in block 1. Any claim for fees or expenses for services rendered during a period or before an official other than the period and official indicated in block 1 will be submitted on a separate CM-972. I have made no agreement and will make no other claim (unless disclosed in block 8) which would entitle me to any portion of the proceeds the client may be awarded under the terms of the Act administered by the Office of Workers' Compensation Programs. I certify that I have furnished a copy of this application and any attachments to the person for whom the above services were performed and to all other parties in the claim. I certify that the information given by me on this application is true and correct to the best of my knowledge. I am aware that severe penalties, including fine and imprisonment, may be invoked under 33 U.S.C. 928(e), as incorporated by 30 U.S.C. 932(a), whenever any person receives an unauthorized fee for services rendered, or under 30 U.S.C 941 whenever any person willfully makes a false or misleading statement or representation for the purpose of obtaining payment under 30 U.S.C. 901 et. seq.

10. Signature of Representative _____
 11. Date _____
 12. Telephone No. (Include Area Code) _____

13. Name and Address of Representative _____
 14. Representative's Social Security Number or IRS Identification Number _____

Instructions for Completing CM-972

Block 4 - Services Rendered

Column (b) - Itemize the services rendered on behalf of the claimant, such as: attend conference, draft letter, prepare interrogatories, etc.

Column (c) – Enter the professional status of the person who performed the services on behalf of the claimant, such as: attorney, paralegal, law clerk, lay clerk, lay representative, clerical, or other person (specify).

Column (d) – Enter the customary billing rate per hour at the time of service for each person who performed services on behalf of the claimant.

Block 5 - Miscellaneous Expenses

Column (b) – Itemize reasonable unreimbursed expenses, incurred by the representative or by an employee of the representative in establishing the claimant's case, e.g. travel expenses, long distance phone calls, etc. **All available receipts or other documentation of expenses must be attached.** Please add client's name, Miner's name (if different), DOL's Case ID Number and representative's name to any attachments.

Note: List the type and amount of any expenses for which you were reimbursed in this case.

<u>Type of Expense</u>	<u>Amount</u>
_____	_____
_____	_____
_____	_____

Block 9 – Escrow Account/Expense Advances

Indicate amount placed in an escrow account and / or itemize amount paid by claimant to the representative for any expenses.

Privacy Act Notice

The following information is provided in accordance with the Privacy Act of 1974, 5 U.S.C. 552a. (1) Collection of this information is authorized by the Black Lung Benefits Act, 30 U.S.C. 901 et. seq. and implementing regulations. (2) The information will be used to determine services and amounts payable under the Act. (3) This information may be used by other agencies or persons handling matters relating, directly or indirectly, to processing this form including liable coal mine operators and their insurance carriers; contractors providing automated data processing or other services to the Department of Labor; representatives of the parties to the claim; and federal, state or local agencies. This would include legal representatives; state workers' compensation agencies or the Social Security Administration, the Internal Revenue Service and other federal, state, and local agencies for the purpose of conducting investigations relating to the payment of services; and debt collection agencies and credit bureaus for the purpose of collecting overpayments that might be made. (4) Furnishing all requested information will facilitate the claims adjudication process, and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of services payable. (Disclosure of your social security number is voluntary; the failure to disclose such number will result in the denial of any right, benefit or privilege to which an individual may be entitled.)

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 42 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the U.S. Department of Labor, Division of Coal Miner Workers' Compensation, Room N-3464, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. (DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.)**

Notice

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.

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