

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 Worker's 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 at 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: \_\_\_\_\_

before the: (Check only one block) \_\_\_\_\_ (Client's Name - Last, First, Middle Initial)

District Director [ ] Administrative Law Judge [ ] Benefits Review Board [ ] Other [ ] (specify) \_\_\_\_\_

2. Miner's Name

3. Miner's Claim Number

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

Table with 5 columns: (a) Date Rendered, (b) Itemized services rendered, (c) Professional Status of Person Who Performed the Service, (d) Usual Billing Rate Per Hour at Time of Service, (e) Time to Nearest 1/4 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)

Table with 3 columns: (a) Date Rendered, (b) Itemize unreimbursed expenses incurred in connection with claim, (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.

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?

Yes [ ] No [ ] If YES, show amount:

9. Did you request monies from this claimant to place in an escrow account or to use as expense advances?

Yes [ ] No [ ] If YES, show amount: and itemize on separate sheet. (See Reverse)

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 official indicated in block 1.

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 status (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), miner's Claim 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:

Type of Expense	Amount

### 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.

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#### Privacy Act Statement

The following information is provided in accordance with the Privacy Act of 1974. (1) Submission of this information is required under the Black Lung Benefits Act. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant or beneficiary, or have complied with the provisions of 20 CFR 410 or 20 CFR 725. (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 benefits. (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.)

#### 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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