

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE
*(Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See
Privacy Act Notice

1. CLAIMANT NAME	CLAIMANT SSN	2. WAGE EARNER NAME, IF DIFFERENT
3. CLAIMANT CLAIM NUMBER, IF DIFFERENT	4. SPOUSE'S NAME, IF NOT WAGE EARNER	SPOUSE'S CLAIM NUMBER OR SSN

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. I have additional evidence to submit. <input type="checkbox"/> Yes <input type="checkbox"/> No Name and address of source of additional evidence: _____ (Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)	7. Do not complete if the appeal is a Medicare issue. Check one of the blocks: <input type="checkbox"/> I wish to appear at a hearing. <input type="checkbox"/> I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)
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You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

Regardless of the issue you are appealing, you should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc., in No. 9.

8. CLAIMANT'S SIGNATURE- Optional	DATE	9. REPRESENTATIVE'S NAME	DATE
RESIDENCE ADDRESS		ADDRESS <input type="checkbox"/> ATTORNEY <input type="checkbox"/> NON-ATTORNEY	
CITY	STATE	ZIP CODE	CITY
TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER	FAX NUMBER

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING

10. Request received for the Social Security Administration on _____ by: _____
(Date) (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? YES NO
 If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> List of legal referral and service organizations provided 13. Interpreter needed <input type="checkbox"/> Yes <input type="checkbox"/> No Language (including sign language): _____ 14. Check one: <input type="checkbox"/> Initial Entitlement Case <input type="checkbox"/> Disability Cessation Case <input type="checkbox"/> Other Postentitlement Case 16. HO COPY SENT TO: _____ HO on _____ <input type="checkbox"/> CF Attached: <input type="checkbox"/> Title II; <input type="checkbox"/> Title XVI; <input type="checkbox"/> Title VIII; <input type="checkbox"/> T XVIII; <input type="checkbox"/> Title II CF held in FO <input type="checkbox"/> Electronic Folder <input type="checkbox"/> CF requested <input type="checkbox"/> Title II; <input type="checkbox"/> Title XVI; <input type="checkbox"/> Title VIII; <input type="checkbox"/> T XVIII (Copy of email or phone report attached) 17. CF COPY SENT TO: _____ HO on _____ <input type="checkbox"/> CF Attached: <input type="checkbox"/> Title II; <input type="checkbox"/> Title XVI; <input type="checkbox"/> Title XVIII <input type="checkbox"/> Other Attached: _____	15. Check all claim types that apply: <input type="checkbox"/> RSI only (RSI) <input type="checkbox"/> Title II Disability-worker or child only (DIWC) <input type="checkbox"/> Title II Disability-Widow(er) only (DIWW) <input type="checkbox"/> SSI Aged only (SSIA) <input type="checkbox"/> SSI Blind only (SSIB) <input type="checkbox"/> SSI Disability only (SSID) <input type="checkbox"/> SSI Aged/Title II (SSAC) <input type="checkbox"/> SSI Blind/Title II (SSBC) <input type="checkbox"/> SSI Disability/Title II (SSDC) <input type="checkbox"/> Title XVIII (HI/SMI) <input type="checkbox"/> Title VIII Only (SVB) <input type="checkbox"/> Title VIII/Title XVI (SVB/SSI) <input type="checkbox"/> Other - Specify: _____
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PRIVACY ACT STATEMENT

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Sections 205(a) (42 U.S.C. 405 (a)), 702 (42 U.S.C. 902), 1631(e) (1) (A), and; (B) (42 U.S.C. 1383(e) (1) (A) and (B)), 1839(i) (42 U.S.C. 1395r), 1869(b) (1), and (c) (42 U.S.C. 1395ff) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to continue processing your claim.

Providing this information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Medicare benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigate activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing Disability Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or any local Social Security office.

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 and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on 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.*