SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0269

# REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **signed 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. ☐ Yes ☐ 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:
- ☐ I wish to appear at a hearing.
- ☐ 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)

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.
**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.**

| 8. (CLAIMANT'S SIGNATURE) (DATE) | 9. (REPRESENTATIVE'S SIGNATURE/NAME) (DATE) |
|---|---|
| ADDRESS | (ADDRESS) ☐ ATTORNEY; ☐ NON-ATTORNEY; |
| CITY STATE ZIP CODE - | CITY STATE ZIP CODE - |
| 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 _____ (Date) by: _____ (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 ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): _____

14. Check one:
- ☐ Initial Entitlement Case
- ☐ Disability Cessation Case
- ☐ Other Postentitlement Case

16. HO COPY SENT TO: _____ HO on _____
- ☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII;
- ☐ Title II CF held in FO ☐ Electronic Folder
- ☐ CF requested ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII
(Copy of email or phone report attached)

17. CF COPY SENT TO: _____ HO on _____
- ☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title XVIII
- ☐ Other Attached: _____

15. Check all claim types that apply:

| | |
|---|---|
| ☐ RSI only | (RSI) |
| ☐ Title II Disability-worker or child only | (DIWC) |
| ☐ Title II Disability-Widow(er) only | (DIWW) |
| ☐ SSI Aged only | (SSIA) |
| ☐ SSI Blind only | (SSIB) |
| ☐ SSI Disability only | (SSID) |
| ☐ SSI Aged/Title II | (SSAC) |
| ☐ SSI Blind/Title II | (SSBC) |
| ☐ SSI Disability/Title II | (SSDC) |
| ☐ Title XVIII | (HI/SMI) |
| ☐ Title VIII Only | (SVB) |
| ☐ Title VIII/Title XVI | (SVB/SSI) |
| ☐ Other - Specify: _____ | |

**Privacy Act Statement**
**Collection and Use of Personal Information**

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), and 1869(b)(1) and (c) (42 U.S.C. 1395ff) of the Social Security Act authorizes us to collect this information. We will use the information you provide to continue processing your claim. The information you provide on this form is voluntary. However, failure to provide all or part of the requested information could prevent us from making an accurate and timely decision on your claim.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. 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 the Social Security 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, General Services Administration, National Archives Records Administration, 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 and administered benefit programs for repayment of payments or delinquent debts under these programs. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is available in our System of Records Notice entitled, Claims Folder System, 60-0089. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at any 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.***