

**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	2. Claimant SSN	3. Claim Number, if different
------------------	-----------------	-------------------------------

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Department of 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.

5. I have additional evidence to submit. <input type="checkbox"/> Yes <input type="checkbox"/> No Name and source of additional evidence, if not included.  Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.	6. Do not complete if the appeal is a Medicare issue. Otherwise, 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)
---	---

**Representation:** You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL)	DATE	8. NAME OF REPRESENTATIVE (if any)	DATE
RESIDENCE ADDRESS		ADDRESS	
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**

9. Request received on \_\_\_\_\_ (Date) by: \_\_\_\_\_ (Print Name) \_\_\_\_\_ (Title)

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

10. Was the request for hearing received within 65 days of the reconsidered determination? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, attach claimant's explanation for delay and supporting documents if any.	15. Check all claim types that apply: <input type="checkbox"/> Retirement and Survivors Insurance 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"/> Title XVI (SSI) Aged only (SSIA) <input type="checkbox"/> Title XVI Blind only (SSIB) <input type="checkbox"/> Title XVI Disability only (SSID) <input type="checkbox"/> Title XVI/Title II Concurrent Aged Claim (SSAC) <input type="checkbox"/> Title XVI/Title II Concurrent Blind (SSBC) <input type="checkbox"/> Title XVI/Title II Concurrent Disability (SSDC) <input type="checkbox"/> Title XVIII Hospital/Supplementary Insurance (HI/SMI) <input type="checkbox"/> Title VIII Only Special Veterans Benefits (SVB) <input type="checkbox"/> Title VIII/Title XVI (SVB/SSI) <input type="checkbox"/> Other - Specify:
11. If claimant is not represented, was a list of legal referral service organizations provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Interpreter needed <input type="checkbox"/> Yes <input type="checkbox"/> No Language (including sign language):	
13. Check one: <input type="checkbox"/> Initial Entitlement Case <input type="checkbox"/> Disability Cessation Case or <input type="checkbox"/> Other Postentitlement Case	
14. HO COPY SENT TO: _____ HO on _____ <input type="checkbox"/> Claims Folder (CF) Attached: <input type="checkbox"/> Title (T) II; <input type="checkbox"/> T XVI; <input type="checkbox"/> T VIII; <input type="checkbox"/> T XVIII; <input type="checkbox"/> T II CF held in FO <input type="checkbox"/> Electronic Folder <input type="checkbox"/> CF requested <input type="checkbox"/> T II; <input type="checkbox"/> T XVI; <input type="checkbox"/> T VIII; <input type="checkbox"/> T XVIII (Copy of email or phone report attached)	
16. CF COPY SENT TO: _____ HO on _____ <input type="checkbox"/> CF Attached: <input type="checkbox"/> Title (T) II; <input type="checkbox"/> T XVI; <input type="checkbox"/> T XVIII <input type="checkbox"/> Other Attached:	

---

**PRIVACY ACT STATEMENT**  
**Request for Hearing by Administrative Law Judge**

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 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 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](http://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](http://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.*