

**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	2. WAGE EARNER, IF DIFFERENT	3. SOC. SEC. CLAIM NUMBER	4. SPOUSE'S CLAIM NUMBER
		- -	- -

**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 Office of Hearings and Appeals 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. 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).)

[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) <input type="checkbox"/> ATTORNEY; <input type="checkbox"/> 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)	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"/> HI Entitlement (HIE) <input type="checkbox"/> Title VIII Only (SVB) <input type="checkbox"/> Title VIII/Title XVI (SVB/SSI) <input type="checkbox"/> Other - Specify: _____
11. Was the request for hearing received within 65 days of the reconsidered determination? <input type="checkbox"/> YES <input type="checkbox"/> 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. <b>HO COPY SENT TO:</b> _____ HO on _____ <input type="checkbox"/> CF Attached: <input type="checkbox"/> Title II; <input type="checkbox"/> Title XVI; <input type="checkbox"/> Title VIII; or <input type="checkbox"/> Title II CF held in FO to establish CAPS ORBIT; or <input type="checkbox"/> CF requested <input type="checkbox"/> Title II; <input type="checkbox"/> Title XVI <input type="checkbox"/> Title VIII (Copy of teletype or phone report attached)	
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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).)

[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) <input type="checkbox"/> ATTORNEY; <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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	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"/> HI Entitlement (HIE) <input type="checkbox"/> Title VIII Only (SVB) <input type="checkbox"/> Title VIII/Title XVI (SVB/SSI) <input type="checkbox"/> Other - Specify: _____
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. <b>HO COPY SENT TO:</b> _____ HO on _____ <input type="checkbox"/> CF Attached: <input type="checkbox"/> Title II; <input type="checkbox"/> Title XVI; <input type="checkbox"/> Title VIII; or <input type="checkbox"/> Title II CF held in FO to establish CAPS ORBIT; or <input type="checkbox"/> CF requested <input type="checkbox"/> Title II; <input type="checkbox"/> Title XVI <input type="checkbox"/> Title VIII (Copy of teletype or phone report attached)	
17. <b>CF COPY SENT TO:</b> _____ HO on _____ <input type="checkbox"/> CF Attached: <input type="checkbox"/> Title II; <input type="checkbox"/> Title XVI <input type="checkbox"/> Other Attached: _____	

## PAPERWORK/PRIVACY ACT NOTICE

The Social Security Act (sections 205(a), 702, 1631(e)(1)(a) and (b), and 1869(b) (1) and (c), and Public Law 106-169 (Section 809(a)(1) of Sections 251(a)) as appropriate) authorizes the collection of information on this form. We need the information to continue processing your claim. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration. We explain, in the Federal Register, these and other reasons why we may use or give out information about you. If you would like more information, get in touch with any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post.

**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 THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. **Send only comments relating to our time estimate to this address, not the completed form.***