,SOCIAL SECURITY ADMINISTRATION | TOE 710 | Form Approved OMB No. 0960-0347

RESPONSE TO NOTICE OF REVISED DETERMINATION

DO NOT WRITE IN THIS SPACE

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF WAGE EARNER OR SELF EMPLOYED PERSON (IF DIFFERENT FROM CLAIMANT)	SOCIAL SECURITY NUMBER
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

TYPE OF BENEFIT:	DISABILITY	SSI
	☐ WORKER ☐ WIDOW ☐ CHILD	☐ DISABILITY ☐ BLIND ☐ CHILD

I wish to appear at a Disability Hearing (includes representative appearing) ☐ YES ☐ NO

I have additional evidence or information to submit ☐ YES ☐ NO

If "Yes," check as many as appropriate:
☐ EVIDENCE ATTACHED ☐ I WILL FURNISH THE FOLLOWING EVIDENCE: (DESCRIBE)

☐ I cannot furnish any or all additional evidence. I have the following information or sources of evidence to provide:

I NEED AN INTERPRETER ☐ YES ☐ NO

If "Yes," complete this line → LANGUAGE | CHECK ONE ☐ SSA NEEDS TO PROVIDE INTERPRETER ☐ I WILL PROVIDE INTERPRETER

NAME OF REPRESENTATIVE (IF ANY)	REPRESENTATIVE'S ADDRESS	TELEPHONE NUMBER (INCLUDE AREA CODE)

SIGNATURE (FIRST NAME, MIDDLE INITIAL, LAST NAME) (WRITE IN INK) | DATE (MONTH, DAY, YEAR)

SIGN HERE ▶ | TELEPHONE NUMBER (INCLUDE AREA CODE)

MAILING ADDRESS (NUMBER AND STREET, APT. NO., P.O. BOX, OR RURAL ROUTE)

CITY AND STATE | ZIP CODE

Witnesses are required ONLY if this form has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (NUMBER AND STREET, CITY, STATE ZIP CODE)	ADDRESS (NUMBER AND STREET, CITY, STATE ZIP CODE)

PRIVACY ACT NOTICE: The Social Security.Administration is authorized to collect the information on this form under regulation 20 CFR 404.992 and 416.1492. Giving us the information on this form is voluntary. However, if you do not respond, we will make a decision based on the evidence in your file.

The Social Security Administration will use the information on this form to fully evaluate your claim for disability benefits. We may routinely give out the information on this form without your consent if:

1. We need to get more information to decide if you are eligible for benefits;
2. An agency needs this information to decide if you are eligible for a health or income program such as SSI State supplementary payments, food stamps, Medicaid, energy assistance, Veterans benefits, or Basic Educational Opportunity Grants;
3. A Federal law requires that we give out this information;
4. Your Congressman or the President's office needs this information to answer questions you ask them;
5. Someone needs this information to do statistical research or audit reports for us related to the Social Security programs, or;
6. The Department of Justice needs the information to represent the Federal Government in a court suit related to SSA administered programs.

These and other reasons why information about you may be used or given out are explained in the Federal Register. If you would like more information about this, get in touch with any Social Security office.

Computer Matching Statement: 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.

PAPERWORK REDUCTION ACT STATEMENT: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 30 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.