

SOCIAL SECURITY ADMINISTRATION

TOE 710

Form Approved  
OMB No. 0990-0822

**REQUEST FOR RECONSIDERATION**

(Do not write in this space)

|  |  |
|--|--|
| NAME OF CLAIMANT                           | NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from claimant.)          |
| SOCIAL SECURITY CLAIM NUMBER               | SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER |
| SPOUSE'S NAME (Complete ONLY in SSI cases) | SPOUSE'S SOCIAL SECURITY NUMBER (Complete ONLY in SSI cases)                       |

CLAIM FOR (Specify type, e.g., retirement, disability, hospital insurance, SSI, SVB, etc.) hospital/medical

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

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**SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY**

(See the three ways to appeal in the How To Appeal Your Supplemental Security Income (SSI) Or Special Veterans Benefit (SVB) Decision instructions.)

"I want to appeal your decision about my claim for Supplemental Security Income (SSI) or Special Veterans Benefits (SVB). I've read about the three ways to appeal. I've checked the box below."

Case Review     Informal Conference     Formal Conference

**EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH**

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.

|                    |   |
|--------------------|---|
| CLAIMANT SIGNATURE | SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE<br><input type="checkbox"/> NON-ATTORNEY <input type="checkbox"/> ATTORNEY |
|--------------------|---|

|                                      |       |          |                                      |       |          |
|--------------------------------------|-------|----------|--------------------------------------|-------|----------|
| MAILING ADDRESS                      |       |          | MAILING ADDRESS                      |       |          |
| CITY                                 | STATE | ZIP CODE | CITY                                 | STATE | ZIP CODE |
| TELEPHONE NUMBER (include area code) |       | DATE     | TELEPHONE NUMBER (include area code) |       | DATE     |

**TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION**

See list of initial determinations

|  |  |
|--|--|
| 1. HAS INITIAL DETERMINATION BEEN MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO   | 2. CLAIMANT INSISTS ON FILING <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. IS THIS REQUEST FILED TIMELY? <input type="checkbox"/> YES <input type="checkbox"/> NO<br><i>(If "NO", attach claimant's explanation for delay and attach only pertinent letter, material, or information in social security office.)</i> |  |

|   |                                 |
|---|---------------------------------|
| RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)                  | SOCIAL SECURITY OFFICE ADDRESS: |
| <input type="checkbox"/> NO FURTHER DEVELOPMENT REQUIRED (GN 03102.300)                             |                                 |
| <input type="checkbox"/> REQUIRED DEVELOPMENT ATTACHED  |                                 |
| <input type="checkbox"/> REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS |                                 |

|   |   |   |  |
|---|---|---|--|
| ROUTING INSTRUCTIONS (CHECK ONE) -----> | <input type="checkbox"/> DISABILITY DETERMINATION SERVICES (ROUTE WITH DISABILITY FOLDER) | <input type="checkbox"/> PROGRAM SERVICE CENTER | <input type="checkbox"/> DISTRICT OFFICE RECONSIDERATION |
|   | <input type="checkbox"/> ODO, BALTIMORE   | <input type="checkbox"/> OIO, BALTIMORE         | <input type="checkbox"/> CENTRAL PROCESSING SITE (SVB)   |
|   | <input type="checkbox"/> OEO, BALTIMORE   |   |  |

NOTE: 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.

**ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS**  
(See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

**Title II**

1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

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**Title XVI**

1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

**Title VIII (See VB 02501.035)**

1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II--items 3, 4, 10, 11 & 16.

**Title XVIII**

1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial) of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).
4. *Initial determinations regarding Medicare Part B income-related premium subsidy reductions*

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OMB No. 0960-0622

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|--------------------|---|

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**TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION**

See list of initial determinations

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|                                  | <input type="checkbox"/> OED, BALTIMORE   |   |  |

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Claims Folder

## HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

There are three different ways to appeal. You can pick the appeal that fits your case. You can have a lawyer, friend, or someone else help you with your appeal.

Here are the three ways to appeal:

### 1. CASE REVIEW:

You can give us more facts to add to your file. Then we'll decide your case again. You don't meet with the person who decides your case.

You can pick this kind of appeal in all cases.

### 2. INFORMAL CONFERENCE:

You'll meet with the person who will decide your case. You can tell that person why you think you're right. You can give us more facts to help prove you're right. You can bring other people to help explain your case.

You can pick this kind of appeal in all SSI cases *except* two. You can't have it if we turned down your SSI application for medical reasons or because you're not blind. Also you can't have it if we're giving you SSI but you disagree with the date we said you became blind or disabled. In SVB cases, you can pick this kind of appeal only if we're stopping or lowering your SVB payment.

### 3. FORMAL CONFERENCE:

This is a meeting like an informal conference. Plus, we can make people come to help prove you're right. We can do this even if they don't want to help you. You can question these people at your meeting.

You can pick this kind of appeal only if we're stopping or lowering your SSI or SVB payment. You can't get it in any other case.

Now you know the three kinds of appeals. You can pick the one that fits your case. Then fill out the front of this form. We'll help you fill it out.

There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

**NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789-U4) FOR YOUR APPEAL.**

The information on this form is authorized by regulation (20 CFR 404.907-404.921, 416.1407-416.1421, 408.1009), Public Law 106-169 (section 809(a)(1) of section 251(a)), and the Social Security Act (Title XVIII (1869(b))). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

~~SEE Revised Form Attached~~  
**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 8 minutes to read the instructions, gather the facts, and answer the questions. SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213. Send only comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401.**

*The following revised PRA Statement will be inserted into the form at its next scheduled reprinting:*

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