| REQUE | ST FOR CHANGE | IN TIME/PLACE OF DI | SABILITY | HEARING | (DO NO | T WRITE IN THIS SPACE) | | |
|--|---|----------------------------------|--------------|--|---|-------------------------|--|--|
| Paperwork Act/Pr | ivacy Act Notice: Th | ne collection of information | by use of th | nis form is authorized | 1 | | | |
| we cannot act on v | our request without the | and 416.1497-416.1421. W | ou furnish | sponses are voluntary, n may be disclosed by | , | | | |
| the Social Security | Administration to and | Off | ency only | with respect to social | | | | |
| security programs | and to comply with I other government agen | revised Paperwork | | change of information | l . | | | |
| NAME OF CLAIMA | | Tiveduction Act and | · | / / | 1 | | | |
| NAME OF CLAMMA | AINT | Privacy Act | | | | | | |
| | | Statements. | | | | | | |
| NAME OF WAGE I | EARNER OR SELF-EMI | PLOYED PERSON | SOCIAL SEC | CURITY NUMBER | | | | |
| SPOUSE'S NAME SECURITY INCOM | | TY NUMBER (COMPLETE C | NLY IN SUF | PPLEMENTAL | | | | |
| | | DISABILITY | | | SSI | | | |
| TYPE OF BENEFIT: | ☐ WORKER | H WIDOW/ | HILD | D DISABILITY | ☐ BLIND ☐ CHILD | | | |
| NAME OF REPRES | SENTATIVE, IF ANY | | | | | | | |
| REPRESENTATIVE | 'S ADDRESS | | | | TELEPHON | NE NUMBER (INCLUDE | | |
| | | | | | AREA CO | · | | |
| HEARING CURREN | ITLY SCHEDULED | | | | | | | |
| DATE | TIME | PLACE | | | | | | |
| REQUEST | | TLEMENT OF THE SCHEDULED HEARING | i | A DIFFERENT PLACE | OF HEARIN | G (SPECIFY PLACE) | | |
| THE REASON FOR | I R MY REQUEST IS: | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| SIGNATURE (FIRST NAME, MIDDLE INITIAL, LAST NAME) (WRITE IN INK) | | | | | | DATE (MONTH, DAY, YEAR) | | |
| SIGN HERE | | | | | TELEPHONE NUMBER (INCLUDE AREA CODE) | | | |
| MAILING ADDRES | S (NUMBER AND STF | REET, APT. NO., P.O. BOX, | OR RURAL F | ROUTE) | | | | |
| CITY AND STATE | | | | | | ZIP CODE | | |
| | | form has been signed by | | | | | | |
| | | sting reconsideration mu | | | addresses | S. | | |
| 1. SIGNATURE OF WITNESS | | | | 2. SIGNATURE OF WITNESS | | | | |
| ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE) | | | | ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE) | | | | |

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 R See below for conduct or sponsor, and you are no revised Paperwork nd to, a collection of information unless it displays a value of the time it will take you about 15 minut Privacy Act Statements.

The Paperwork Reduction Act and seed to notify you that this information provided the clearance requirements of 995. We may not not revised Paperwork and to, a collection of motion may not revised Paperwork Reduction Act and Privacy Act Statements.

| Paperwork Act/Priregulation 20 CFR | ST FOR CHANG vacy Act Notice: T 404,907-404.921 an | he collection of id 416.1407-416 | information b 5.1421. While | y use of this t your respons | form is authorized by | y e | WRITE IN THIS SPACE) | | |
|--|--|--|----------------------------------|---------------------------------|--|-------------------------|-------------------------|--|--|
| Social Security Acsecurity programs | request without this drainistration to ano and to comply withouther government ago | ther person or Federal laws | See below revised Park Reduction | aperwork | be disclosed by the th respect to social inge of information | .1 | | | |
| NAME OF CLAIMA | ANT | | Privacy A | | | | | | |
| | | | Statemen | | | | | | |
| NAME OF WAGE I | EARNER OR SELF-EN | MPLOYED PERS | | | URITY NUMBER | - | | | |
| SPOUSE'S NAME SECURITY INCOM | AND SOCIAL SECUI E CASE) | RITY NUMBER | (COMPLETE C | DNLY IN SUPP | PLEMENTAL | | | | |
| TYPE OF | | DISABILIT | ·Y | | | SSI | | | |
| TYPE OF BENEFIT: | ☐ WORKER | ☐ WORKER ☐ WIDOW/ ☐ CHILD ☐ DISABILITY | | | DISABILITY | ☐ BLIND | ☐ CHILD | | |
| _ | ENTATIVE, IF ANY | | | | | | | | |
| REPRESENTATIVE | 'S ADDRESS | | | | | TELEPHON AREA COD | E NUMBER (INCLUDE E) | | |
| HEARING CURREN | ITLY SCHEDULED | | | | | <u> </u> | | | |
| DATE | TIME | PLACE | | | | | | | |
| REQUEST | | TITLEMENT OF M THE SCHEDU | | , | DIFFERENT PLACE | OF HEARING | G (SPECIFY PLACE) | | |
| THE REASON FOR | MY REQUEST IS: | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| SIGNATURE (FIRST NAME, MIDDLE INITIAL, LAST NAME) (WRITE IN INK) | | | | | | DATE (MONTH, DAY, YEAR) | | | |
| LIEDE | | | | | TELEPHONE NUMBER (INCLUDE AREA CODE) | | | | |
| MAILING ADDRES | S (NUMBER AND ST | TREET, APT. NO | D., P.O. BOX, | OR RURAL R | OUTE) | | | | |
| CITY AND STATE | | | | | | Z | IP CODE | | |
| | | | | | | | two witnesses to the | | |
| signing who know the person requesting reconsideration must si 1. SIGNATURE OF WITNESS 2 | | | | | 2. SIGNATURE OF WITNESS | | | | |
| ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE) | | | | ADDRESS | ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE) | | | | |

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 350% of the Paperwork Red See below for conduct or sponsor, and you are not revised Paperwork to, a collection of information unless it displays a valid Reduction Act and that it will take you about 15 minutes Privacy Act privacy Act Statements.

Statements.

| REQUE | ST FOR CHANGE IN TIME/I | PLACE OF DIS | ABILITY | HEARING | (DO NO | T WRITE IN THIS SPACE) | | |
|-------------------|--|------------------------|-----------------|-----------------------|-------------------------|---------------------------|--|--|
| Paperwork Act/Pri | ivacy Act Notice: The collection of | of information by | use of this | form is authorized by | y | | | |
| regulation 20 CFR | 404.907-404.921 and 416.1407-4 request without this information. | 16.1421. While y | our respon | ses are voluntary, we | | | | |
| Social Security A | dministration to another person of | See below for | Or | ith respect to socia | | | | |
| security programs | and to comply with Federal laws | revised Pap | | nange of information | | | | |
| between SSA and o | other government agencies. | | | / | | | | |
| NAME OF CLAIMA | ANT | Reduction A | ici and | | | | | |
| | | Privacy Act | | | | | | |
| | | Statements. | | | | | | |
| NAME OF WAGE | EARNER OR SELF-EMPLOYED PEF | RSON S | OCIAL SEC | URITY NUMBER | | | | |
| | | | | | | | | |
| CDOLLCE'S NAME | AND SOCIAL SECURITY NUMBER | /COMPLETE ON | I V IN CUD | DIEMENTAL | 1 | | | |
| SECURITY INCOM | | (COMPLETE ON | LI IN SUF | FLEWIENTAL | | | | |
| | , | | | | | | | |
| | DISABIL | ITY | | | SSI | | | |
| TYPE OF | ☐ WORKER ☐ WIDO | W/ | . 5 | П | ☐ BLIND ☐ CHILD | | | |
| BENEFIT: | WIDO WIDO | WER L CHI | LD | ☐ DISABILITY | | | | |
| NAME OF REPRES | ENTATIVE, IF ANY | | | | | | | |
| | | | | | | | | |
| REPRESENTATIVE | 'S ADDRESS | | | | | IE NUMBER (INCLUDE | | |
| | | | | | AREA COL | DE) | | |
| | | | | | | | | |
| HEARING CURREN | | | | | | | | |
| DATE | TIME PLACE | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 1 | A POSTENTITLEMENT O | | | DIFFERENT PLACE | OF HEARIN | G (SPECIFY PLACE) | | |
| REQUEST | DATE | OCCED HEARING | | | | | | |
| THE REASON FOR | L MY REQUEST IS: | | | | | | | |
| THE REACON TON | TWT TIEGEST TO. | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| SIGNATURE (FIRS | T NAME, MIDDLE INITIAL, LAST | NAMEL/M/RITE IN | INK) | | DATE (MO | MTH DAV VEAR) | | |
| SIGNATORE (TINS | T NAME, MIDDLE INTIAL, LAST | IVAIVIL/ (VVIII IL IIV | TINIX / | | DATE (MONTH, DAY, YEAR) | | | |
| SIGN | | | | | | TELEPHONE NUMBER (INCLUDE | | |
| HERE | | | | | | AREA CODE) | | |
| | | | | | | | | |
| MAILING ADDRES | S (NUMBER AND STREET, APT. N | NO., P.O. BOX, OF | RURAL R | OUTE) | | | | |
| | | | | | | | | |
| CITY AND STATE | | | | | | ZIP CODE | | |
| | | | | | | | | |
| | equired ONLY if this form has b | | | | | | | |
| signing who kno | w the person requesting recor | sideration must | sign belo | w, giving their full | addresses |), | | |
| 1. SIGNATURE O | F WITNESS | 2. SIGNA | TURE OF WITNESS | | | | | |
| | | | | | | | | |
| ADDRESS (NUMB | ER AND STREET, CITY, STATE, Z | IP CODE) | ADDRESS | (NUMBER AND STR | EET, CITY, | STATE, ZIP CODE) | | |
| | | | | | | | | |

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 and privacy Act the time it will take to read the instruction of the Paperwork Reduction Act and Privacy Act Statements.

| | | NGE IN TIME/PLACE O | | | | · · | WRITE IN THIS SPACE) | |
|--|---|---|-----------------|---------------------------|--|-------------------------|----------------------|--|
| regulation 20 CFR cannot act on your Social Security Ac | 404.907-404.92 request without dministration to | : The collection of informat 1 an See below for re this anot Paperwork Redu with Act and Privacy tage Statements. | vised uction | respon tish ma only | form is/authorized by ses are voluntary, we be disclosed by the with respect to social change of information | | | |
| NAME OF CLAIMA | ANT | Statements. | | _ | | | | |
| | | | | | | | | |
| | TARNER OR OF | E EMBLOYED DEDOOM | lagge | | NIDITY NUMBER | ļ | | |
| NAME OF WAGE | EARNER OR SEL | F-EMPLOYED PERSON | Soci | IAL SEC | CURITY NUMBER | | | |
| SPOUSE'S NAME SECURITY INCOM | | CURITY NUMBER (COMPLE | ETE ONLY | IN SUP | PLEMENTAL | | | |
| | | DISABILITY | | | | SSI | | |
| TYPE OF BENEFIT: | ☐ WORKE | R WIDOW/ WIDOWER | CHILD | | DISABILITY | ☐ BLIND | ☐ CHILD | |
| NAME OF REPRES | ENTATIVE, IF A | NY | | | | | | |
| REPRESENTATIVE | 'S ADDRESS | | | | | TELEPHONE | E NUMBER (INCLUDE | |
| THE THE SERVICE OF TH | O ADDITEOS | | | | | AREA COD | | |
| HEARING CURREN | ITLY SCHEDULE | D | | | | | | |
| DATE | TIME | PLACE | | | | | | |
| REQUEST | | ENTITLEMENT OF | ARING | | DIFFERENT PLACE | OF HEARING | (SPECIFY PLACE) | |
| THE REASON FOR | MY REQUEST I | S: | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| SIGNATURE (FIRST | T NAME MIDDL | E N T AL, LAST NAME) (W | RITE IN INI | K) | | DATE (MON | NTH, DAY, YEAR) | |
| _ | T IVAIVIE, WIIDDE | E INTIAL, EAST NAME, (W | | 10, | | BATE (MONTH, BAT, TEAR) | | |
| HERE HERE | | | | | TELEPHONE NUMBER (INCLUDE AREA CODE) | | | |
| MAILING ADDRES | S (NUMBER AN | O STREET, APT. NO., P.O. E | BOX, OR R | URAL F | OUTE) | | | |
| CITY AND CTATE | | | | | | | P CODE | |
| CITY AND STATE | | | | | | | I CODE | |
| | | f this form has been signerequesting reconsideration | | | | | | |
| 1. SIGNATURE OF WITNESS | | | 2. | SIGNA | TURE OF WITNESS | | | |
| ADDD500 | ED AND 0777 | OUTV OTATE 717 000 ==: | 1 | UDBESS | (NUMBER AND STR | FET CITY 4 | STATE ZIP CODE | |
| ADDRESS (NUMB | EK AND STREET | , CITY, STATE, ZIP CODE) | AL | סטחבסט | HADIMIDEL WIND STR | LLI, GIII, 3 | TATE, ZIF CODE! | |

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 Papery Conduct or sponsor, and you information unless it display and Privacy Act Statements. We may not to, a collection of information unless it display that it will take you about 15 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

SSA will insert the following revised PRA Statement into the form at its next scheduled reprinting:

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the <u>Paperwork Reduction Act of 1995</u>. 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 15 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.**

Privacy Act Statement

Collection and Use of Personal Information

Sections 205, 1631(d)(1), and 1872 of the Social Security Act, as amended, and 20 C.F.R Parts 404.907-404.921, and 416.1407-416.1421, authorize us to collect this information. The purpose of collecting this information is to track hearing office workload from the receipt of a request for a hearing until the final hearing level disposition. Your response is voluntary. However, failure to provide the requested information may prevent you from receiving a new time or place of the hearing.

We rarely use the information provided on this form for any purpose other than for changing the time/place of disability hearing. In accordance with 5 U.S.C.§ 552a(b) of the Privacy Act, however, we may disclose the information provided on this form 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 Medicare benefits 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 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 investigative activities necessary to assure the integrity of Medicare programs.

We may also use the information you provide in computer matching programs. Matching programs compare our 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 benefits programs and for repayment of payments or delinquent debts under these programs.

Explanations about these and other reasons why information you provide us may be used are available in Systems of Record Notice (SORN) 60-0009 (Hearings and Appeals Case Control System, SSA, Office of Disability Adjudication and Review) and SORN 60-0010 (Hearing Office Tracking System of Claimant Cases, SSA, Office of Disability Adjudication and Review). The notices, additional information about this form, and any other information regarding our systems and programs are available on-line at www.socialsecurity.gov or at your local Social Security office.