Social Security Administration | TOE 710 | Form Approved OMB No. 0960-0348

REQUEST FOR CHANGE IN TIME/PLACE OF DISABILITY HEARING

(DO NOT WRITE IN THIS SPACE)

Paperwork Act/Privacy Act Notice: The collection of information by use of this form is authorized by regulation 20 CFR 404.907-404.921 and 416.1407-416.1421. While your responses are voluntary, we cannot act on your request without thi ou furnish may be disclosed by the Social Security Administration to anot ency only with respect to social security programs and to comply with Fe ure or exchange of information between SSA and other government agenc

See below for revised Paperwork Reduction Act and Privacy Act Statements.

NAME OF CLAIMANT

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON | SOCIAL SECURITY NUMBER

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)

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

NAME OF REPRESENTATIVE, IF ANY

REPRESENTATIVE'S ADDRESS | TELEPHONE NUMBER (INCLUDE AREA CODE)

HEARING CURRENTLY SCHEDULED

DATE	TIME	PLACE

I REQUEST

☐ A POSTENTITLEMENT OF _____ DAYS FROM THE SCHEDULED HEARING DATE

☐ A DIFFERENT PLACE OF HEARING (SPECIFY PLACE)

THE REASON FOR 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 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)

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 995. We may not conduct or sponsor, and you are no nd to, a collection of information unless it displays a val mber. We estimate that it will take you about 15 minut form. This includes the time it will take to read the instr necessary facts and fill out the form

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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 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 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.