REQUEST FOR CHANGE IN TIME/PLACE OF DISABILITY HEARING

NAME OF CLAIMANT

(DO NOT WRITE IN THIS SPACE)

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

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)

SIGN HERE ▶

DATE (MONTH, DAY, YEAR)

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

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.

COMPUTER MATCHING SYSTEM: 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.

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PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 8 minutes to read the instructions, gather the necessary facts, and answer the questions.

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