Privacy Act / Paperwork Reduction Notice

Section 1860 D-14 of the Social Security Act, as amended, authorizes us to collect this information. The information you provide will be used to determine if you are eligible for help paying your share of the cost of a Medicare Prescription Drug Plan.

The information you furnish on this form is voluntary. However, failure to provide this requested information could prevent an accurate and timely decision on your appeal.

We rarely use the information you supply for any purpose other than for making a determination about your continuing entitlement to benefits. However, we may use it for the administration and integrity of Social Security prog isclose information to another person or to another agency in accordance w uses, which include but are not limited to the following:

See below for revised Privacy Act Statement.

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/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 and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

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

A complete list of routine uses for this information is available in our System of Records Notice entitled Medicare Database (60-0321). This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at **www.socialsecurity.gov** or at your local Social Security office.

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 10 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: Social Security Administration, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

Form Approved
OMB No. 0960-0695

Appeal of Determination for Extra Help with Medicare Prescription Drug Plan Costs

FOR OFFICIAL USE ONLY
Date received:
Office code: ☐☐☐ Request filed late: ☐

1. Applicant's Name:

_____

2. Social Security Number:

_____

3. Medicare Number (if different from Social Security number):

_____

4. Spouse's Name (if spouse lives at same address as you):

_____

5. Spouse's Social Security Number (if spouse lives at same address as you):

_____

6. Spouse's Medicare Number (if different from spouse's Social Security number and spouse lives at same address as you):

_____

7. Please explain why you disagree with our decision:

_____

_____

8. Do you have additional information to support your appeal?

☐ **YES** Send the additional information with this form to the address shown on the bottom of page 2.

☐ **NO**

9. Do you want a hearing? If you have a hearing, it will be by telephone.

☐ **YES** You will receive a notice with the date and time of the hearing. Please complete questions 10 through 13.

☐ **NO** You will receive a decision based on the information available and any additional information you provide.

10. To give you time to prepare for the hearing, we must allow at least 20 days between the date of your request and the date we schedule the hearing. Do you want a hearing sooner if scheduling permits?

☐ **YES**

☐ **NO**

11. Do you need an interpreter?

☐ **YES** (Specify language): _____

☐ **NO**

12. Are you hearing impaired?

☐ **YES**

☐ **NO**

13. Will you have other people at the hearing?

☐ **YES**

☐ **NO**

If **YES**, will you and the other people need to talk to us from more than one telephone number?

☐ **YES** We call this a conference call. When we send you the notice scheduling the hearing, we will give you a telephone number to use for this conference call and additional instructions for setting up this call.

☐ **NO**

Please return your completed appeal form, including the signature page, and any additional information to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1030
Wilkes-Barre, PA 18767-1030

Signatures

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 to the best of my knowledge. I understand that making a false statement is a crime punishable under Federal law. By submitting this appeal, I am authorizing the Social Security Administration to obtain and disclose information related to my income, resources and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, benefits, and pensions.

Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.

SECTION A

Your Signature:	Phone Number: (____) ____ – ____
Your Home Street Address:	Apt. #:
City: / State:	ZIP Code:
Your Mailing Street Address (if different from home address):	Apt. #:
City: / State:	ZIP Code:

If you recently changed your address, put an X here: ☐

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

Print First Name:	Print Last Name:	Phone Number: (____) ____ – ____

SECTION B

If someone assisted you, place an X in the box that describes that person and provide the rest of the information requested below.

☐ Family Member ☐ Attorney ☐ Advocate ☐ Other Specify: _____

☐ Friend ☐ Agency ☐ Social Worker _____

Print First Name:	Print Last Name:	Phone Number: (____) ____ – ____
Address:		Apt. #:
City: / State:		ZIP Code:

Privacy Act Statement

Collection and Use of Personal Information

Section 1860 D-14 of the Social Security Act, as amended, allows us to collect this information. We will use the information you provide to determine your eligibility for help paying your share of the cost of a Medicare Prescription Drug Plan.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the requested information could prevent an accurate and timely decision on your appeal.

We rarely use the information you supply for any purpose other than for making a determination about your continuing entitlement to benefits. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0321, entitled Medicare Database. Additional information about this and other system of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Instructions for Completing the Appeal of Determination for Extra Help with Medicare Prescription Drug Plan Costs

WHEN TO USE THIS FORM: Use Form SSA-1021 to appeal Social Security's determination regarding eligibility or continuing eligibility for Extra Help with your Medicare prescription drug plan costs.

1. *APPLICANT'S NAME:*

   Print name as it appears on your Social Security card.

2. *SOCIAL SECURITY NUMBER:*

   Print social security number as it appears on your Social Security card.

3. *MEDICARE NUMBER:*

   Complete only if your Medicare number is different from your Social Security number.

4. *SPOUSE'S NAME:*

   Print name as it appears on your spouse's Social Security card. Complete only if your spouse lives at the same address.

5. *SPOUSE'S SOCIAL SECURITY NUMBER:*

   Print Social Security number as it appears on your spouse's social security card. Complete only if your spouse lives at the same address.

6. *SPOUSE'S MEDICARE NUMBER:*

   Complete only if your spouse lives at the same address and his or her Medicare number is different from his or her Social Security number.

7. *PLEASE EXPLAIN WHY YOU DISAGREE WITH OUR DECISION:*

   Briefly state the determination that you disagree with and why you disagree with that determination. You can add to this statement by attaching additional pages.

8. *DO YOU HAVE ADDITIONAL INFORMATION TO SUPPORT YOUR APPEAL:*

   If there is more information you want us to see, you can mail it with this form to:

   Social Security Administration
   Wilkes-Barre Data Operations Center
   P.O. Box 1030
   Wilkes-Barre, PA 18767-1030

9. *DO YOU WANT A HEARING?*

   Check YES if you want a hearing by telephone. Check NO if you do not want a hearing by telephone. If you do not want a hearing we will make a decision based on the information we have available and any additional information you provide. We call this a case review.

10. *DO YOU WANT A HEARING SOONER IF SCHEDULING PERMITS?*

    We must allow at least 20 days from the date we receive your appeal request and the date

we schedule the hearing to give you time to prepare. If you want a hearing sooner, check YES. Check NO if you want us to schedule the hearing at least 20 days from the date we receive your appeal request.

11. *DO YOU NEED AN INTERPRETER?*

Check YES and specify the language you prefer and we will provide interpreter services. Check NO if you do not need an interpreter.

12. *ARE YOU HEARING IMPAIRED?*

Check YES if you require the use of a telecommunications device for the deaf to communicate. Check NO if you are not hearing impaired.

13. *WILL YOU HAVE OTHER PEOPLE AT THE HEARING?*

Check YES if you will have people other than yourself on the telephone conversation. Check NO if you will not have any other people at the hearing by the telephone. If YES, will you and the other people need to talk to us from more than one telephone number? Check YES if you will have people calling in from a telephone number different from yours. Otherwise, check NO.

SEND THE FORM:

Please return your completed appeal form, including the signature page, and any additional information to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1030
Wilkes-Barre, PA 18767-1030