

**REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE**

*(Take or mail the completed 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)*

See  
Privacy Act Notice

1. Claimant Name	2. Claimant SSN	3. Claim Number (if different from SSN)
------------------	-----------------	---

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

5. I have additional evidence to submit.  Yes  No  
Name and source of additional evidence, if not included.

Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.

6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks.

I wish to appear at a hearing.

I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

**Representation:** You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL)		DATE	8. NAME OF REPRESENTATIVE (if any)		DATE
RESIDENCE ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER ( ) ( )	FAX NUMBER ( ) ( )	TELEPHONE NUMBER ( ) ( )	FAX NUMBER ( ) ( )		

**TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION - ACKNOWLEDGMENT OF REQUEST FOR HEARING**

9. Request received on \_\_\_\_\_ by \_\_\_\_\_ (SSA)  
 (Date) (Print Name) (Title)  
 (Address) (Servicing FO Code) (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination?  YES  NO If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided?  Yes  No

12. Interpreter needed  Yes  No  
Language (including sign language) \_\_\_\_\_

13. Check one:  Initial Entitlement Case  
 Disability Cessation Case or  Other Postentitlement Case

14. HO COPY SENT TO: \_\_\_\_\_ HO on \_\_\_\_\_

Claims Folder (CF) Attached:  Title(T)II  T XVI  
 T VIII  T XVIII  
 T II CF held in FO  Electronic Folder  
 CF Requested  T II  T XVI  T VIII  T XVIII  
 (Copy of email or phone report attached)

15. Check all claims that apply:

- Retirement and Survivors Insurance Only (RSI)
- Title II Disability-Worker or child only (DIWC)
- Title II Disability-Widow(er) only (DIWW)
- Title XVI (SSI) Aged only (SSIA)
- Title XVI Blind only (SSIB)
- Title XVI Disability only (SSID)
- Title XVI/Title II Concurrent Aged Claim (SSAC)
- Title XVI/Title II Concurrent Blind (SSBC)
- Title XVI/Title II Concurrent Disability (SSDC)
- Title XVIII Hospital/Supplementary Insurance (HI/SMI)

16. CF COPY SENT TO: \_\_\_\_\_ HO on \_\_\_\_\_

CF Attached:  Title(T) II  T XVI  T XVIII

Other Attached: \_\_\_\_\_

Title VIII Only Special Veterans Benefits (SVB)

Title VIII/Title XVI

(SVB/SSI)

Other – Specify \_\_\_\_\_

Form HA-501-U5 (00-0000) EF(00-0000) TAKE OR MAIL THE ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS

## PRIVACY ACT STATEMENT

### Request for Hearing by Administrative Law Judge

Sections 205(a) (42 U.S.C. 405 (a)), 702 (42 U.S.C. 902), 1631(e) (1) (A), and; (B) (42 U.S.C. 1383(e) (1) (A) and (B)), 1839(i) (42 U.S.C. 1395r), 1869(b) (1), and (c) (42 U.S.C. 1395ff) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to continue processing your claim.

Providing this information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency 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 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 the 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 investigate activities necessary to assure the integrity of Social Security programs.

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 System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing **Disability** Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov) or any 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.

**TAKE OR MAIL 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](http://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.*