

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 if Supplemental Security Income Case)		

Type of Benefit:	Disability			SSI		
	<input type="checkbox"/> Worker	<input type="checkbox"/> Widow/Widower	<input type="checkbox"/> Child	<input type="checkbox"/> Disability	<input type="checkbox"/> Blind	<input type="checkbox"/> Child

Name of Representative, if any

Representative's Address	Telephone Number (Include area code)
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Hearing Currently Scheduled

Date	Time	Place
Request	<input type="checkbox"/> A postentitlement of _____ days from the scheduled hearing date	<input type="checkbox"/> 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)
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Mailing Address (Number and street, Apt. No., P.O. Box, or Rural Route)

City and State	ZIP Code
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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

Address (Number and Street, City, State, and ZIP Code)

2. Signature of Witness

Address (Number and Street, City, State, and ZIP Code)

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~~Privacy Act Statement Collection and Use of Personal Information~~

See Revised Privacy Act &
PRA Statements attached

~~Section 205(b) of the Social Security Act, as amended, allows us to collect this information. We will use the information you provide to attempt to reschedule a disability hearing based on good cause, eligibility, and availability.~~

~~Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent you from receiving a new time or place of the hearing.~~

~~We rarely use the information you supply for any purpose other than what we state above, 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); and,~~
- ~~2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).~~

~~A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices, 60-0009, entitled Hearings and Appeals Case Control System, and 60-0010, entitled Hearing Office Tracking System of Claimant Cases. Additional information about these and other system of records notices and our programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.~~

~~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 incorrect payments or delinquent debts under these programs.~~

~~**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 (OMB) control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.~~