

## RESPONSE TO NOTICE OF REVISED DETERMINATION

DO NOT WRITE IN THIS SPACE

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF WAGE EARNER OR SELF EMPLOYED PERSON (IF DIFFERENT FROM CLAIMANT)	SOCIAL SECURITY NUMBER
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

TYPE OF BENEFIT:	DISABILITY	SSI
	<input type="checkbox"/> WORK <input type="checkbox"/> WIDOW <input type="checkbox"/> CHILD	<input type="checkbox"/> DISABILITY <input type="checkbox"/> BLIND <input type="checkbox"/> CHILD

I wish to appear at a Disability Hearing (includes representative appearing)  YES    NO

I have additional evidence or information to submit  YES    NO

If "Yes," check as many as appropriate:

- EVIDENCE ATTACHED                       I WILL FURNISH THE FOLLOWING EVIDENCE: (DESCRIBE)

I cannot furnish any or all additional evidence. I have the following information or sources of evidence to provide:

I NEED AN INTERPRETER  YES    NO

If "Yes," complete this line	LANGUAGE	CHECK ONE	<input type="checkbox"/> SSA NEEDS TO PROVIDE INTERPRETER
		<input type="checkbox"/> I WILL PROVIDE INTERPRETER	

NAME OF REPRESENTATIVE (IF ANY)	REPRESENTATIVE'S ADDRESS	TELEPHONE NUMBER (INCLUDING AREA CODE)
---------------------------------	--------------------------	--

FIRST NAME, MIDDLE INITIAL, LAST NAME	DATE (MONTH, DAY, YEAR)
	TELEPHONE NUMBER (INCLUDING AREA CODE)

MAILING ADDRESS (NUMBER AND STREET, APT. NO., P.O. BOX, OR RURAL ROUTE)

CITY AND STATE	ZIP CODE
----------------	----------

## Privacy Act Statement Collection and Use of Personal Information

Sections 205(a) and 1631(e) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision regarding Social Security benefits.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

- To third party contacts, where necessary, to establish or verify information provided by representative payees or payee applicants; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784 and 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at [www.ssa.gov/privacy](http://www.ssa.gov/privacy).

## 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 30 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.