**UNITED STATES DISTRICT COURT**
**NORTHERN DISTRICT OF FLORIDA**

**COMPLAINT FOR REVIEW OF ADVERSE SOCIAL SECURITY DECISION**

_____,

_____,
*(Write the full name of each Plaintiff who is filing this complaint. If the names of all the Plaintiffs cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names.)*

**v.**

**Case No.: _____**
*(To be filled in by the Clerk's Office)*

_____,

**COMMISSIONER OF SOCIAL SECURITY ADMINISTRATION,**
*(Write the full name of the current Commissioner of the Social Security Administration. Do not include addresses here.)*
_____/

This complaint seeks judicial review of the decision of the Commissioner of Social Security pursuant to § 205(g) and/or § 1631(c)(3) of the Social Security Act, 42 U.S.C. § 405(g), 1383(c)(3).

Pursuant to Federal Rule of Civil Procedure 5.2, papers filed with the Court should ***not*** contain: an individual's full social security number or taxpayer-identification number, full birth date, full name of a person known to be a minor; or a complete financial account number. Any paper filing may include ***only***: the last four digits of a social security number, the year of an individual's birth; a minor's initials; and the last four digits of a financial account number.

Except as noted on this form, Plaintiff should not submit exhibits, affidavits, grievance or witness statements, or any other such materials to the Clerk's Office with this complaint.

## I. PARTIES TO THIS COMPLAINT

A. Plaintiff

Plaintiff's Name: _____

Address: _____

_____

City and County: _____

State, and Zip Code: _____

Telephone: _____ *(Home)* _____ *(Cell)*

Email Address: _____

Last Four Digits of Social Security Number: _____

B. Defendant

Defendant's Name: _____
*(Name of Current Social Security Commissioner)*

Address: _____

_____

City, State, and Zip Code: _____

## II. BASIS FOR JURISDICTION

This is an action seeking judicial review of a decision of the Commissioner of the Social Security Administration. Jurisdiction may be based on two statutes. If the complaint seeks review of a decision regarding Disability Insurance Benefits under Title II of the Social Security Act, jurisdiction is proper under 42 U.S.C. § 405(g). If the complaint seeks review of a decision regarding Supplemental Security Income under Title XVI of the Social Security Act, jurisdiction is proper under 42 U.S.C. § 1383(c)(3). Please check the type of claim you are filing.

Type of Claim:

□ Disability Insurance Benefits Claim (Title II)

□ Supplemental Security Income Claim (Title XVI)

□ Child Disability Claim

□ Widow or Widower Claim

If this case is filed on another wage earner's record:

Wage Earner's Full Name: _____

Last Four Digits of Wage Earner's Social Security Number _____

An appeal from a decision of the Commissioner must be filed within 60 days of the date on which you received notice that the Commissioner's decision became "final." If the Appeals Council denied the request for review, then the Administrative Law Judge's decision is the "final decision" of the Commissioner subject to judicial review pursuant to§ 405(g) and/or § 1383(c)(3).

When did you receive notice? _____ *(This is likely the date on which you received notice from the Social Security Appeals Council that your appeal was denied*.)

Attach to this Complaint, a copy of the Commissioner's final decision, and a copy

of the notice you received from the Social Security Appeals Council stating that your complaint was denied.

## III. STATEMENT OF CLAIM

A. Basis for a Claim

Federal courts may overturn decisions by the Commissioner of Social Security only if the decision was not supported by substantial evidence in the record or was based on legal error.

State why the Commissioner's decision should be overturned: (*check all that apply*)

□ The Commissioner found the following facts to be true, but those facts are not supported by substantial record evidence because: _____

_____

_____

_____

_____

□ The Commissioner's decision was based on legal error because: _____

_____

_____

_____

_____

B. Relevant Information

1. Plaintiff is entitled to receive Disability Insurance Benefits and/or Supplemental Security Income Benefits because of the following disability or disabilities: _____

_____

2. The disability began on this date: _____
3. The Social Security Administration denied Plaintiff's application for Disability Insurance benefits and/or Supplemental Security Income benefits on this date: _____

_____

4. If Plaintiff requested a hearing, the hearing before the Administrative Law Judge was held on this date: _____
5. The Administrative Law Judge denied Plaintiff's claim on this date: *(date of ALJ decision)*: _____
6. Plaintiff requested review by the Social Security Appeals Council on this date: _____

## IV. RELIEF REQUESTED

Plaintiff respectfully requests that: (*check all that apply*)

□ Defendant's decision be modified and monthly maximum insurance benefits be granted to Plaintiff, retroactive to the date of initial disability.

□ In the alternative, this case be remanded to Defendant for reconsideration of the evidence.

□ Any further relief as may be just and proper under the circumstances of this case be granted.

## V. CERTIFICATION

As required by Federal Rule of Civil Procedure 11, I certify by signing below that to the best of my knowledge, information, and belief, this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a non-frivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and, (4) the complaint otherwise complies with the requirements of Rule 11.

I agree to timely notify the Clerk's Office if there is any change to my mailing address. I understand that my failure to keep a current address on file with the Clerk's Office may result in the dismissal of my case.

Date: _____ Plaintiff's Signature: _____

Printed Name of Plaintiff: _____

Address: _____

_____

E-Mail Address: _____

Telephone Number: _____