

SOAR OAT Data Form

Applicant and Person Assisting Applicant Information (not collected in OAT)

Name of Person Assisting Applicant: _____

Agency Name: _____

Phone Number: _____ Email: _____

Applicant First Name: _____ Applicant Last Name: _____

Date of Birth: _____ (mm/dd/yyyy) SS#: _____

Demographics

Gender: Female Male Age: _____

Military Service? Yes No Don't Know (Skip for child applicants)

If yes: Military Discharge Status: _____

Was applicant receiving VA Disability Compensation at time of application? Yes No Don't Know

Was the applicant receiving county, state or other public assistance (cash or health insurance) prior to applying for SSI/SSDI? Yes (check all that apply):
 TANF Medicaid General/Public Assistance
 No
 Don't Know

Was the applicant working during the application process? Yes – Working Earnings per month: \$ _____
 No
 Don't Know

What was the applicant's housing status at the time of the application?

- | | |
|--|---|
| <input type="checkbox"/> Outdoors (e.g. street, abandoned or public building) | <input type="checkbox"/> Housing First |
| <input type="checkbox"/> Shelter | <input type="checkbox"/> HUD funded voucher |
| <input type="checkbox"/> Transitional | <input type="checkbox"/> Permanent Supportive Housing |
| <input type="checkbox"/> Own or someone else's apartment, room or house | <input type="checkbox"/> Foster care |
| <input type="checkbox"/> SRO, boarding house | <input type="checkbox"/> Residential facility for children or youth |
| <input type="checkbox"/> Residential treatment for adults | <input type="checkbox"/> Unaccompanied youth |
| <input type="checkbox"/> Institution (psychiatric or other hospital, nursing home, etc.) | <input type="checkbox"/> Fleeing domestic violence |
| <input type="checkbox"/> Jail or correctional facility | |

Length of time homeless (i.e. length of time homeless *prior* to working on the SOAR application or *prior* to entering the current housing situation): _____ years and _____ months

Application Type (Please check one)

- Initial SOAR Application - *Filing an initial SSI/SSDI application with SSA* (Complete section A only)
- Reconsideration using SOAR – *Initial application was denied and you are filing a Request for Reconsideration* (Complete section B only)
- Administrative Law Judge (ALJ) Hearing using SOAR – *Reconsideration denied (or prototype state) and you are filing a Request for ALJ Hearing* (Complete section C only)
- Non-SOAR Claim – *Not a SOAR applicant and no SOAR critical components are used* (Complete section D only)

Section A: Initial SOAR Application

Application Detail

Protective filing date (initial contact with SSA) _____ / _____ / _____ (mm/dd/yyyy)

Was an SSA-1696 Appointment of Representative form submitted? Yes No

Were medical records collected and submitted? Yes No

Was a Medical Summary Report (MSR) written and submitted? Yes No

Was the MSR co-signed by physician or psychologist? Yes No

Was a quality review of the application done prior to submission? Yes No

Has a complete application packet been submitted to SSA?

Yes

No

Was a Consultative Exam (CE) ordered? Yes No

If yes, how many? _____

Application date (packet submitted to SSA): _____ / _____ / _____

Application will not submitted to SSA due to:

Moved Disappeared Incarcerated

Withdrew Transferred to new representative

Other: _____

Decision

Has there been notification of a decision? No – Case is still pending

Unknown

Yes

Date of final decision: _____ / _____ / _____ (mm/dd/yyyy)

Outcome of decision

Approved

(Go to Post-Decision Questions)

Denied

Reason for denial (from the SSA denial letter):

Earning SGA No significant impairment

Ability to do past work Ability to do other work

Substance use is material Duration requirements

Failure to cooperate Non-medical

Unknown

Was a reconsideration or appeal filed?

Yes No

My state doesn't have reconsideration, filed appeal

B. Reconsideration Using SOAR

Application Detail

Date of request for reconsideration _____ / _____ / _____ (mm/dd/yyyy)

Was an SSA-1696 Appointment of Representative form submitted? Yes No

Were additional medical records collected and submitted? Yes No

Was a Medical Summary Report (MSR) written and submitted? Yes No

Was the MSR co-signed by physician or psychologist? Yes No

Was a quality review of the application done prior to submission? Yes No

Was a Consultative Exam (CE) ordered? Yes No
If yes, how many? _____

D: Non-SOAR Claim

Application Detail

Date of first contact with applicant whose claim was pending: ____ / ____ / ____ (mm/dd/yyyy)

When you began working with applicant, application was pending at the:
(complete A, B, or C)

A. Initial Level

Date of initial decision: ____ / ____ / ____ (mm/dd/yyyy)

Outcome of decision

<p>Approved <i>(Go to Post-Decision Questions)</i></p>	<p>Denied</p> <p>Reason for denial (from the SSA denial letter):</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Earning SGA</td> <td><input type="checkbox"/> No significant impairment</td> </tr> <tr> <td><input type="checkbox"/> Ability to do past work</td> <td><input type="checkbox"/> Ability to do other work</td> </tr> <tr> <td><input type="checkbox"/> Substance use is material</td> <td><input type="checkbox"/> Duration requirements</td> </tr> <tr> <td><input type="checkbox"/> Failure to cooperate</td> <td><input type="checkbox"/> Non-medical</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Unknown</td> </tr> </table> <p>Was a reconsideration or appeal filed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> My state doesn't have reconsideration, filed appeal <input type="checkbox"/> No	<input type="checkbox"/> Earning SGA	<input type="checkbox"/> No significant impairment	<input type="checkbox"/> Ability to do past work	<input type="checkbox"/> Ability to do other work	<input type="checkbox"/> Substance use is material	<input type="checkbox"/> Duration requirements	<input type="checkbox"/> Failure to cooperate	<input type="checkbox"/> Non-medical	<input type="checkbox"/> Unknown	
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<input type="checkbox"/> Unknown											

B. Reconsideration Level

Date of reconsideration: ____ / ____ / ____ (mm/dd/yyyy)

Outcome of decision

<p>Approved <i>(Go to Post-Decision Questions)</i></p>	<p>Denied</p> <p>Reason for denial (from the SSA denial letter):</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Earning SGA</td> <td><input type="checkbox"/> No significant impairment</td> </tr> <tr> <td><input type="checkbox"/> Ability to do past work</td> <td><input type="checkbox"/> Ability to do other work</td> </tr> <tr> <td><input type="checkbox"/> Substance use is material</td> <td><input type="checkbox"/> Duration requirements</td> </tr> <tr> <td><input type="checkbox"/> Failure to cooperate</td> <td><input type="checkbox"/> Non-medical</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Unknown</td> </tr> </table> <p>Was a request for an ALJ hearing submitted?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Earning SGA	<input type="checkbox"/> No significant impairment	<input type="checkbox"/> Ability to do past work	<input type="checkbox"/> Ability to do other work	<input type="checkbox"/> Substance use is material	<input type="checkbox"/> Duration requirements	<input type="checkbox"/> Failure to cooperate	<input type="checkbox"/> Non-medical	<input type="checkbox"/> Unknown	
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C. Administrative Law Judge (ALJ) hearing level

Date of ALJ hearing: ____ / ____ / ____

Date of decision on ALJ ____ / ____ / ____

Outcome of ALJ hearing

<p>Approved <i>(Go to Post-Decision Questions)</i></p>	<p>Denied</p> <p>Reason for denial (from the SSA denial letter):</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Earning SGA</td> <td><input type="checkbox"/> No significant impairment</td> </tr> <tr> <td><input type="checkbox"/> Ability to do past work</td> <td><input type="checkbox"/> Ability to do other work</td> </tr> <tr> <td><input type="checkbox"/> Substance use is material</td> <td><input type="checkbox"/> Duration requirements</td> </tr> <tr> <td><input type="checkbox"/> Failure to cooperate</td> <td><input type="checkbox"/> Non-medical</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Unknown</td> </tr> </table>	<input type="checkbox"/> Earning SGA	<input type="checkbox"/> No significant impairment	<input type="checkbox"/> Ability to do past work	<input type="checkbox"/> Ability to do other work	<input type="checkbox"/> Substance use is material	<input type="checkbox"/> Duration requirements	<input type="checkbox"/> Failure to cooperate	<input type="checkbox"/> Non-medical	<input type="checkbox"/> Unknown	
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<input type="checkbox"/> Failure to cooperate	<input type="checkbox"/> Non-medical										
<input type="checkbox"/> Unknown											

Post-Decision (for ALL approvals)

Approved for SSI/SSDI? SSI Only
 SSDI Only
 Both SSI/SSDI

SSI Award per Month: \$ _____

SSDI Award per Month: \$ _____

Medicaid Reimbursement Amount (in dollars): \$ _____

Medicare Reimbursement: Amount (in dollars): \$ _____

General/Public Assistance Reimbursement Amount (in dollars): \$ _____

Retro Back payments (in dollars): \$ _____

Is the Applicant Working Post-Decision (at time of decision)? Yes No

If yes, Post-Decision Earnings per Month (in dollars): \$ _____

Was applicant housed at time of decision? Yes No

If yes, did access to benefits facilitate housing? Yes No Don't Know

Representative payee needed? Yes No

If yes, Representative payee provided? Yes No

Hours to Complete Claim: _____