**Applicant: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOAR Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **I. Establishing a Protective Filing Date** | | | | | | |
| 1. Was SSA contacted to establish a protective filing date by a method below? Date:  Called SSA Online (by beginning SSDI application) Walked in to SSA | |  | | | | |
| 2. Does the SOAR representative have proof of protective filing in applicant’s records? | | Yes No | | | | |
| **II. SSI/SSDI Applications: Non-Medical Information** | |  | | | | |
| ***A. SSI Application (SSA-8000)*** | |  | | | | |
| 1. Was the SSA-8000 completed: By SOAR representative?  By SSA representative (in-person or by phone)? Date: | |  | | | | |
| 2. Was the following documentation for the SSI application provided, if needed? | |  | | | | |
| (a) Marital status | Yes No N/A | | | | | |
| (b) Immigration status | Yes No N/A | | | | | |
| (c) Living arrangements | Yes No N/A | | | | | |
| (d) Assets/resources | Yes No N/A | | | | | |
| (e) Income | Yes No N/A | | | | | |
| 1. ***SSDI Application (SSA-16)*** | |  | | | | |
| 1. Was the SSA-16 completed and submitted:  Online In-person By phone Date: | | | | |  | |
| 2. Did the Date of Onset match the date reported on the SSA-3368? Yes No | | | | |  | |
| ***C. Appointment of Representative (SSA-1696)*** | |  | | | | |
| 1. Was the SSA-1696 signed and submitted? Yes No Date: | |  | | | | |
| **III. SSI/SSDI Applications: Medical Information** | | | | | | |
| ***D. Adult Disability Report (SSA-3368)*** | | | | | |  |
| 1. Was the SSA-3368 completed and submitted:  Online In-person By phone Date: | | | | | |  |
| 2. On the SSA-3368, was the following information provided: | | | |  | | |
| 1. Additional contact person besides appointed representative? | | | | Yes No | | |
| 1. ALL physical and mental health conditions? | | | | Yes No | | |
| 1. Last grade completed, and details about special education or specialized training? | | | | Yes No | | |
| (d) Employment details about the 5 most recent jobs in the past 15 years with best estimates of tasks, duration, pay, and dates worked? | | | | Yes No | | |
| (e) Comprehensive listing of treatment providers (addresses, phone numbers, and dates, where possible) for ALL past and current physical and mental health treatment, including:  (a) Reasons for treatment and treatment provided?  (b) Medications currently taking or prescribed, what they are for, and ALL side effects?  (c) All recent medical tests with approximate dates and location? | | | | Yes No  Yes No  Yes No | | |
| 3. Are ALL questions answered completely, with any clarifications included in remarks? | | | | Yes No | | |
| 4. Was information about the applicant’s last date worked consistent across all forms? | | | | Yes No | | |
| **IV. Medical Records** | | | |  | | |
| ***E. Authorization to Disclose Information (SSA-827)*** | | | |  | | |
| 1. Was a signed and dated SSA-827 submitted to SSA, either in-person or online? | | | | Yes No | | |
| 1. Were medical records provided to SSA or DDS? | | | | Yes No | | |
| **V. Medical Summary Report (MSR)** | |  | | | | |
| ***Introduction****:* | |  | | | | |
| 1. The applicant’s physical description, including their behavior, mannerisms, and dress? | | | Yes No | | | |
| 1. All of the applicant’s mental and physical health diagnoses? | | | Yes No | | | |
| 1. Information/observations that illustrate the applicant’s symptoms and functioning? | | | Yes No | | | |
| ***Personal History****:* | | |  | | | |
| 1. Brief overview of personal history as it relates to the applicant’s conditions and functioning? If trauma history is included, does it currently impact the applicant’s conditions and functioning? | | | Yes No | | | |
| 1. Educational history, including information on learning difficulties, grades repeated, special education, relationships with other students and teachers? | | | Yes No | | | |
| 1. Legal history as it relates to symptoms of their illness, with information about treatment in jail/prison? | | | Yes No | | | |
| 1. Problems in current or past personal/intimate relationships, including problems with children? | | | Yes No | | | |
| ***Occupational History***: | | |  | | | |
| Employment history for past 15 years, including all jobs, reasons for leaving, job skills, problems with task completion and relationships with supervisors and co-workers? | | | Yes No | | | |
| ***Substance Use:*** | | |  | | | |
| History and treatment, including reasons for use, impact of use, treatment history, and any periods of sobriety with a focus on the applicant’s symptoms while sober? | | | Yes No | | | |
| ***Physical Health History****:* | | |  | | | |
| Brief history of symptoms and treatment, with a focus on physical health in the previous 2-3 years? If no treatment now, why? Information on how the conditions impact the applicant’s ability to sit/stand/walk/carry objects? | | | Yes No | | | |
| ***Mental Health History****:* | | |  | | | |
| Brief history of symptoms and treatment at all providers, with a focus on mental health in the previous 2-3 years? Is there a current mental status exam? If no current treatment, why? Is context for treatment included, rather than a list of dates? | | | Yes No | | | |
| ***Functional Information:*** | | |  | | | |
| 1. Description of all four areas of functioning: 1) understand, remember, or apply information; 2) interact with others; 3) concentrate, persist, or maintain pace; and 4) adapt or manage oneself | | | Yes No | | | |
| 1. Are functional impairments directly linked with symptoms of the applicant’s mental or physical health conditions using detailed examples and quotes? | | | Yes No | | | |
| 1. Are difficulties with activities of daily living integrated into the descriptions of the four functional areas? | | | Yes No | | | |
| ***Summary:*** | | |  | | | |
| 1. Does the report contain a brief summary of the evidence presented in the MSR? | | | Yes No | | | |
| 2. Is report co-signed by a physician/psychiatrist or psychologist? | | | Yes No | | | |
| 3. Are names and phone numbers included for the SOAR representative and the co-signing doctor? | | | Yes No | | | |

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| **Date complete application packet with medical records and MSR delivered to SSA/DDS:** | |  | |
| **Date SSI/SSDI decision received:** | **Outcome of application:**  Approval Denial | | |
| **Was information added to local SOAR data tracking system (OAT, HMIS, other)?** | | | Yes No |