



New York SOAR Process

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SOAR Social Security Administration (SSA) Application Process

1. The SOAR Service Provider will:
 - Have the potential applicant complete and sign a “SOAR Consent for Release of Information.”
 - Fax the completed/signed SOAR Consent form to the designated SSA office contact person.
2. The local SSA office contact person will:
 - Identify the applicant’s SSA status (application/appeal pending/suspended record or is currently receiving SSI/SSDI benefits) and fax the SOAR Consent form back to the SOAR Service Provider within 5 business days.
 - If there is no application/appeal pending/suspended record, the SSA local contact will treat the SOAR Consent as intent to file a claim and protect the filing date.
 - The return fax from SSA will serve as a receipt for the protective filing date.
3. Within a *maximum* of 60 days of the protective filing date, the SOAR Service Provider will hand-deliver the following to the local SSA office contact. (NOTE: The on-line forms are completed and submitted at the same time the paperwork is delivered to SSA).

A SOAR Application Packet for Initial Claims includes these forms and documents:

- A completed SOAR Checklist
- A completed SSA-8000 (SSI application) along with any needed supportive documentation.
- Submission of the Internet Social Security Claim (iClaim), the on-line SSDI application.
- Submission of the Internet Disability Report (i3368).
- Signed SSA releases of information for each treatment source (SSA-827, Authorization to Disclose Information to the SSA).
- A completed SSA-1696 (Appointment of Representative form).
- A completed SSA-8510 (Authorization for SSA to Obtain Personal Information)
- Medical records and collateral information
- A medical summary report documenting functional impairments (co-signed by physician or psychologist, if possible)

IMPORTANT: Service providers **MUST** be aware that missing the 60-day deadline will result in a termination of the protective filing period and the need to start over. This can result in an individual not receiving the benefits to which she or he is entitled. During this time, SSA may send a “close-out letter” to the applicant advising him or her of the need to complete the application and notifying the individual of the possibility that the claim will be terminated if the deadline is missed. This is a routine letter and will not cancel the 60-day period.

4. From the protective filing date to the submission of the above information, the SOAR Service Provider will consult with the SSA representative and the DDD contact with any questions.
5. SSA mails the claim receipt to the SOAR Service Provider liaison who submitted the SSA-1696.
6. The SSA representative enters an electronic “HOMELESS” Flag. In addition, the SSA representative selects MESSAGE, and adds “SOAR PROJECT.”
7. Upon receipt in the DDD, flagged claims will be sent to the DDD liaison for the assignment of the application to an examiner. The DDD liaison will provide the examiner’s contact information to the SOAR Service Provider who is encouraged to contact the claims examiner early in the process to identify him or herself and to offer assistance to ensure a rapid response to any additional questions or requests for information.



SOAR CHECKLIST for INITIAL CLAIMS

(Complete checklist and place on top of application packet before submitting to SSA.)

Date: _____

Claimant's Name: _____ **SSN:** _____

Caseworker's Name: _____ **Phone #:** _____

Paper Forms

- SSA-8000: Application for Supplemental Security Income (SSI)
- SSA-827: Authorization to Disclose Information to SSA
- SSA-1696: Appointment of Representative
- SSA-8510: Authorization for the Social Security Administration to Obtain Personal Information

If applicable:

- SSA-3373 Function Report (Only needed if a medical summary report according to the SOAR training is **NOT** submitted).
- SSA-4814 Medical Report on Adult with Allegation of Human Immunodeficiency Virus (HIV) Infection

On-line Forms

- SSA-i3368: Internet Disability Report – Submitted on: _____
- SSA-16: Application for Social Security Disability Insurance (SSDI) – Submitted on: _____

Medical Summary Report

Medical Records



SOAR PROJECT
(SSA/SSDI Outreach, Access, and Recovery)

Consent for Release of Information

Sign this form only if you want the Social Security Administration to give information or records about you to (service provider).

TO: Social Security Administration fax Local SSA Office

Customer's Name

Date of Birth Social Security Number

SOAR Service Provider: Name of Staff (Please Print)

Agency Name

I, the undersigned, authorize SSA to release the following information to the SOAR service provider listed below: the date and status of my most current SSI applications or appeals if any and the date and status of my most current SSDI applications and appeals if any. If I was in receipt of benefits and am now in suspense or terminated status, please provide the effective dates. If my most current application(s) was denied, please advise the date(s) of denial and denial reason. If I have a pending appeal please provide the level of appeal that is pending and the date(s) of my appeal(s). If it is at the hearing level please provide the date the reconsideration was denied.

(Service Provider)

(Fax #)

This consent for release of information is in effect from to (not to exceed 1 year). (MMDDYY) (MMDDYY)

I want this information released because I am pursuing entitlement to Social Security disability programs. This consent form is intended to be interpreted as an intent by the undersigned to file for Social Security or Supplemental Security Income benefits. I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information that I provided on this form and that it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: Date: Relationship: (Below, show signatures, names, and addresses of two people if signed by mark.)

Witness #1

Witness #2

(Print Name)

(Print Name)

(Signature)

(Signature)

(Address)

(Address)

(City, State, and Zip code)

(City, State, and Zip code)

THIS SECTION TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION

No Record Supplemental Security Income Social Security Disability Income

Terminated Record Date Terminated _____
MMDDYY

Record in Suspense Effective Date of Suspension _____
MMDDYY

Birth record previously verified by SSA (please check if applicable)

Current Claim Status

<input type="checkbox"/> SSI Claim Pending:	<input type="checkbox"/> SSDI Claim Pending:
Initial Claim Date Filed _____	Initial Claim Date Filed _____
Reconsideration Date Filed _____	Reconsideration Date Filed _____
Hearing Level Date Filed _____	Hearing Level Date Filed _____

<input type="checkbox"/> SSI Claim Denied:	<input type="checkbox"/> SSDI Claim Denied:
Initial Claim Date Denied _____	Initial Claim Date Denied _____
Reconsideration Date Denied _____	Reconsideration Date Denied _____
Hearing Level Date Denied _____	Hearing Level Date Denied _____

(Circle One)

Denial Reason: Medical Non-Medical	Denial Reason: Medical Non-Medical
Other _____	Other _____

Allowance

SSI: Eligibility date _____ SSDI: Eligibility date _____

SSA Claims Information was provided by: _____
(SSA Liaison)

Date of Response _____ Protective Filing Date _____

Telephone Number: _____ SSA Field Office Code: _____