

**1. Intake Summary**Enroll Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Intake Staff Name \_\_\_\_\_

Program Name \_\_\_\_\_ Client ID (Computer Generated) \_\_\_\_\_

**2. Basic Client Profile** (Universal Data Elements)

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

<b>SS#</b>	____ - ____ - ____	<b>Date of Birth</b>	____/____/____ MM DD YYYY
<b>SS Quality</b>	<input type="checkbox"/> Full SSN <input type="checkbox"/> Don't Know or Don't Have <input type="checkbox"/> Partial SSN <input type="checkbox"/> Refused	<b>DOB Type</b>	<input type="checkbox"/> Full DOB <input type="checkbox"/> Don't Know <input type="checkbox"/> Approx or Partial DOB <input type="checkbox"/> Refused
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> Transgendered Male to Female <input type="checkbox"/> Transgendered Female to Male		
<b>Ethnicity</b>	<input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<b>Race</b>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
<b>Veteran Status</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<b>Disabling Condition</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
<b>Residence Prior to Program Entry</b>	<input type="checkbox"/> Emergency shelter <input type="checkbox"/> Transitional housing for homeless persons <input type="checkbox"/> Permanent housing for formerly homeless <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility/detox <input type="checkbox"/> Hospital (non-psychiatric) <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Staying in family member's apartment/house <input type="checkbox"/> Staying in friend's room/apartment/house <input type="checkbox"/> Hotel or motel paid without emergency voucher <input type="checkbox"/> Foster care home or group home <input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Other <input type="checkbox"/> Safe Haven <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with other (non-VASH) subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Permanent housing for formerly homeless <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<b>Length of Stay in Previous Residence</b>	<input type="checkbox"/> One week or less <input type="checkbox"/> More than one week, less than one month <input type="checkbox"/> One to three months <input type="checkbox"/> More than three months, less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
		<b>Zip Code of Last Perm. Residence</b>	_____
		<b>Zip Code Type</b>	<input type="checkbox"/> Full or Partial Zip Code <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused

**3. SOAR Information**

<b>Application Status</b>	<input type="checkbox"/> New SOAR Application (Complete Section A only) <input type="checkbox"/> SOAR-initiated reconsideration or appeal (Complete Section B only) <input type="checkbox"/> Application not initiated using SOAR (Complete Section C only)
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**Section A: New SOAR Application**

1.	Protective filing date (consent form faxed to SSA):	____/____/____ (mm/dd/yyyy)
2.	Application date (application packet submitted to SSA):	____/____/____ (mm/dd/yyyy)
3.	Completed and submitted SSA 1696 Appointment of Representative form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Were medical records collected and submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Was a medical summary report written and submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Was report co-signed by physician or psychologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Was quality review of application done prior to submission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Was a Consultative Exam (CE) ordered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Date of decision:	____/____/____ (mm/dd/yyyy)
10.	Outcome of decision:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
11.	Approved for SSI?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Approved for SSDI?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Representative payee needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Representative payee provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
15.	If denied, was a reconsideration or appeal filed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	If homeless at time of application, date applicant was housed:	____/____/____ (mm/dd/yyyy)

**Section B: Initiated Reconsideration or Appeal**

1.	Did SOAR staff initiate the reconsideration or appeal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Did SOAR staff submit SSA 1696 Appointment of Representative form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Were medical records collected and submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Was a medical summary report written and submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Was an expedited hearing requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Was a review on record requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Did applicant have an attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Date of hearing decision or review on record:	____/____/____ (mm/dd/yyyy)
9.	Outcome of hearing or review on record:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
10.	Approved for SSI?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Approved for SSDI?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Representative payee needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
13.	Representative payee provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section C: Pending Applications (Those Not Initiated Using SOAR)**

1.	Date of first contact with applicant whose claim was pending:	____/____/____ (mm/dd/yyyy)
2.	When you began working with applicant, was application pending at the: a. Initial level? b. Reconsideration level? c. Administrative Law Judge (ALJ) hearing level?	<input type="checkbox"/> Yes (Go to Q.3) <input type="checkbox"/> No <input type="checkbox"/> Yes (Go to Q.4) <input type="checkbox"/> No <input type="checkbox"/> Yes (Go to Q.5) <input type="checkbox"/> No
3.	Initial level a. Date of initial decision: b. Outcome of initial decision (if approved, go to Q.6): c. If denied, was a request for reconsideration filed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Reconsideration level a. Date of reconsideration: b. Outcome of reconsideration (if approved, go to Q.6): c. If denied, was an appeal for an Administrative Law Judge (ALJ) hearing filed?	____/____/____ (mm/dd/yyyy) <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Administrative Law Judge (ALJ) hearing level: a. Date of ALJ hearing decision: b. Outcome of ALJ hearing decision:	____/____/____ (mm/dd/yyyy) <input type="checkbox"/> Approved <input type="checkbox"/> Denied
6.	Approved for SSI?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Approved for SSDI?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Representative payee needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
9.	Representative payee provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**4. Exit Summary**

<b>Exit Date</b>	____/____/____ MM                  DD                  YYYY
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