SOAR Referral

Client Name: _____ Date: _____

Gender: M F Race: _____

Social Security Number: _____ DOB: _____

Does client have a birth certificate and valid ID? YES NO

- If yes please send copies along with referral.
- If no would client like a referral for the Homeless ID project? YES NO

Client Telephone number: _____

Client address: _____

1. Who is the treating/diagnosing psychiatrist? _____
2. Location of client's mental health treatment? _____
3. Is individual homeless or at risk of homelessness? YES NO
4. Is individual connected to case management services? YES NO

   If YES, where: _____
5. Current SSI/SSDI status (Check one):

_____ **Nothing pending (not filed or denied in past)**

_____**Application pending (circle one):** Applied Appealed Hearing Date: _____

_____**Recently denied** Date: _____

_____**Unknown**

6. Is individual receiving any income or other public benefits (Please circle all that apply)?

   TCA TDAP SSI/SSDI FOOD STAMPS

   OTHER: _____
7. Does individual have insurance? MA MEDICARE PRIVATE OTHER NO

RETURN OR FAX: ATTENTION Worcester County Core Service Agency at **410-632-0065**

Referring Agency: _____

Referral by: _____

Contact information: _____

Office use only: Date received: _____

Circle one: **Approved** **Denied** Decision date: _____ Initials: _____

Protective Filing Date: _____ Revised 7.15.14

SOAR Applicant Checklist

***REQUIRED*:**

☐ Individual is diagnosed with a DSM-5 Priority Population Diagnosis, established by the Mental Hygiene Administration, by a psychiatrist:

- ☐ 295.90/F20.9 Schizophrenia
- ☐ 295.40/F20.81 Schizophreniform Disorder
- ☐ 295.70/F25.0 Schizoaffective Disorder, Bipolar Type
- ☐ 295.70/ F25.1 Schizoaffective Disorder, Depressive Type
- ☐ 298.8/F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
- ☐ 298.9/F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder
- ☐ 297.1/ F22 Delusional Disorder
- ☐ 296.33/ F33.2 Major Depressive Disorder, Severe
- ☐ 296.34/F33.3 Major Depressive Disorder, With Psychotic Features
- ☐ 301.22/F21 Schizotypal Personality Disorder
- ☐ 301.83/F60.3 Borderline Personality Disorder
- ☐ 296.43/F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe
- ☐ 296.44/F31.2 Bipolar I Disorder, Current Most Recent Episode Manic, With Psychotic Features
- ☐ 296.53/F31.4 Bipolar I Disorder, Current Most Recent Episode Depressed, Severe
- ☐ 296.54/F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features
- ☐ 296.40/F31.0 Bipolar I Disorder, Current or Most Recent Hypomanic
- ☐ 296.40/F31.9 Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
- ☐ 296.7/F31.9 Bipolar I Disorder, Unspecified
- ☐ 296.89/F60.3 Bipolar II Disorder

☐ Individual is at least 18 years old

☐ Individual is not working due to psychiatric conditions

☐ Individual is currently exhibiting symptoms of mental illness or has periods with worsening of symptoms that prevents sustainable employment.

Depression/Bipolar	**Psychotic d/o**	**Anxiety (trauma) –**	**Cognitive –**
At least 4:	**At least 1:**	**At least 1:**	**At least 1:**
☐ Difficulty falling or staying asleep	☐ See things others say they don't see	☐ Being easily startled	☐ Forgetting names, appointment, etc. with a need for frequent reminders
☐ Changes in appetite	☐ Hear things others say they don't hear	☐ Discomfort with/fear of people being behind you	☐ Difficulties remembering past events in your life
☐ Loss of interest in things you used to enjoy	☐ Feel as though others are looking at or talking about you	☐ Restlessness or nervousness	☐ Difficulties reading, writing, or speaking
☐ Decreased energy that makes activities difficult	☐ Feel as though others are watching you or want to hurt you	☐ Panic attacks	☐ Trouble understanding instructions
☐ Feelings of worthlessness or guilt		☐ Constant feeling of being "on guard"	
☐ Trouble staying focused		☐ Fear that causes you to avoid a particular activity, place, or object	
☐ Thoughts of hurting yourself or others			

Mania – at least 3	*Do you observe:*		
☐ Feelings of extreme energy ☐ A decreased need for sleep ☐ Racing thoughts that make focusing more difficult ☐ Feeling superior to others ☐ Feelings that you can accomplish many tasks ☐ A spending spree you can't afford ☐ Any risky behaviors without worrying for consequences ☐ Impulsivity	☐ Flat or inappropriate affect ☐ Blunted speech ☐ Restricted emotions ☐ Responding to external stimuli	☐ Obsession over something that you must respond to ☐ Nightmares or recurrent thoughts of a traumatic experience	

☐ Individual exhibits functional impairments in three out of the following four areas:

Activities of daily living	**Social functioning**	**Concentration, Persistence, or Pace**	**Decompensation**
☐ Hygiene activities ☐ Cleaning (without prompts) ☐ Trouble getting out of bed ☐ Lack desire to cook ☐ Trouble grocery shopping ☐ Trouble doing laundry ☐ Anxiety or confusion riding public transportation ☐ Trouble budgeting	☐ Lack contact with family ☐ History of poor interpersonal relationships ☐ Isolating behaviors ☐ History of conflicts ☐ Lack of participation in groups ☐ Poor co-worker/supervisor relationships ☐ Anxiety in social settings ☐ Fears that others are targeting	☐ Difficulty focusing on one task ☐ Jumping from task-to-task ☐ Difficulty completing a task ☐ History of starting but not completing a task ☐ Short term memory deficits (appt, etc.) ☐ Long term memory deficits ☐ Easily distracted and require redirection ☐ Require reminders to complete tasks	☐ History of hospitalizations ☐ History of incarcerations ☐ History of medication changes ☐ Treatment plan changes ☐ Disengagement from treatment when more symptomatic

☐ Individual is not working due to medical and/or psychiatric conditions (i.e. not because cannot find work or was laid off)

- ☐ History of failed work attempts (started and stopped employment due to diagnosed disability)
- ☐ Long work history, but can no longer work up to SGA due to conditions
- ☐ Scattered work history due to conditions and other factors
- ☐ Inability to focus on job tasks

SOAR PROJECT
(SSI/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 Worcester County Core Service Agency (service provider).

TO: Social Security Administration fax: _____Local SSA Office_____

Customer's Name_____

Date of Birth_____ Social Security Number_____

THIS SECTION TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION

____No Record ____Supplemental Security Income ____Social Security Disability Income

____Terminated Record _____ SSI Date Terminated _____
MMDDYY

Current Claim Status

____ SSI Claim Pending:		**____ 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 _____
____ SSI Claim Denied:		**____ 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 Other **Denial Reason: Medical Non-Medical**

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:** _____

Service Provider: Kathy Craige 410-632-1100 ext. 1047 Worcester County CSA
Name of Staff and phone # (Please Print) Agency Name

Customer's Name _____

Date of Birth _____ Social Security Number _____

I authorize SSA to release the dates and status of my Social Security Disability Insurance and/or Supplemental Security Income application(s), to:

Worcester County Core Service Agency 410-632-0065
(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.

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

Date: _____

Witness #1

_____
(Print Name)

_____
(Signature)

_____
(Address)

_____
(City, State, and Zip code)

Witness #2

_____
(Print Name)

_____
(Signature)

_____
(Address)

_____
(City. State, and Zip code)