**SOAR Referral Application (2024)**

***Please complete in full and email attachment to*** *Partnershipservicesreferrals@mecklenburgcountync.gov*

**For SOAR SSI/SSDI eligibility the client must be:**

* **Homeless or at risk of homelessness**
* **Have presenting medical and/or psychiatric conditions or symptoms that have existed for a year or more**
* **Currently and consistently receiving treatment, or have a history of treatment for the presenting conditions**
* **Unable to work or has difficulty sustaining employment due to presenting medical and/or psychiatric conditions**

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|  |  |
| --- | --- |
| Referral Date: | Click or tap to enter a date. |

**Referral Source Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Program: |  |
| Phone: |  |  |  |
| Relationship to Client: |  |
| Does the client meet the above eligibility criteria? |  Yes [ ]  No [ ]   |
| Are you providing ongoing case management to the client? |  Yes [ ]  No [ ]   |
| If no, who would be providing ongoing case management? |  |
|  |

**Client Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |   | SSN: |   |
| DOB: |   |  |
| City of Birth: |   | State of Birth: |   |
| Mother’s Maiden Name: |   | Father’s Name: |   |
| Phone: |   | Email Address: |  |
| Current Living Situation (select one):  | Choose an item. |
| If non-suitable place, where?  |  |
| If homeless, how long?  |   |
| If Other, please explain here:  |  |
| **Physical Address:** |  |
| Address Line 2 (optional): |  |
| City/State/Zip: |  |
| **Mailing Address if different than above:** |   |
| Address Line 2 (optional): |  |
| City/State/Zip: |   |
|  |
| Highest Level of Education: |   | Graduated? | Yes [ ]  No [ ]  |
| Name of High School/College: |   |
| Location of High School/College: | City:  |   | State:  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Is the client currently employed? |  Yes [ ]  No [ ]  | If yes, Hourly Rate:  | $ |  |
| If Yes, Hourly Rate:  | $ |  |  | Monthly Income: | $ |  |  |
| Has client every worked? |  Yes [ ]  No [ ]  |  |
| If unemployed, date of last employment? |   |  |
| Is client able to work and earn at least $1,550/month? | Yes [ ]  No [ ]  |  |
| Has the client been convicted of a misdemeanor? | Yes [ ]  No [ ]  |  |
| Has the client been convicted of a felony? | Yes [ ]  No [ ]  |  |
| Are there any pending criminal charges? | Yes [ ]  No [ ]  |  |
| Is the client required to register as a sex offender? | Yes [ ]  No [ ]  |  |
| Has the client applied for social security benefits in the past?  | Yes [ ]  No [ ]  |  |
| If yes, what was the outcome? |  |
| Has the client received social security benefits in the past? | Yes [ ]  No [ ]  |
| If yes, when did the payments stop?  |  | Why? |  |
| Is the client a veteran? | Yes [ ]  No [ ]  | Branch of Service: |  |
| Does the veteran receive VA Disability? | Yes [ ]  No [ ]  |  |
| If yes, Monthly Amount:  | $ |  |  |
| What are your service-connected conditions (VA): |
|  |
|  |
| Does the client have a history of substance use? | Yes [ ]  No [ ]  |  |

**Eligibility Information:**

|  |
| --- |
| Please list all mental and physical health conditions that prevent the client from earning at least $1,550/month:  |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
|  |  |
| Please list all treatment sources (hospitals /behavioral health) that can provide medical records: |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
|  |  |
| Please list all prescribed medications that the client is currently taking:  |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

**Multi-Agency Consent for the Release of Confidential Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

 (Name of Consumer) (Record #) (DOB) (SSN)

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to The Mecklenburg County Department of Community Resources to cancel this consent. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate, and exchange information needed to coordinate and continue care, treatment, and services. If I check no, I do not want the information exchanged with that provider.

|  |  |  |
| --- | --- | --- |
| Yes | No | Provider/Agency Name |
| ❒ | ❒ |  |
| ❒ | ❒ |  |
| ❒ | ❒ |  |
| ❒ | ❒ |  |
| ❒ | ❒ |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes | No | Types of Information | Yes | No | Types of Information |
| ❒ | ❒ | Demographic | ❒ | ❒ | Lab/X-Ray Reports |
| ❒ | ❒ | Assessments | ❒ | ❒ | Admit/Discharge Dates |
| ❒ | ❒ | Physical Exam | ❒ | ❒ | Release/Discharge Summary |
| ❒ | ❒ | Treatment Plan(s) | ❒ | ❒ | Housing Information |
| ❒ | ❒ | Medications | ❒ | ❒ |  |
| ❒ | ❒ | Other: Please describe: |

**Date, Event or Condition when Consent Expires**: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. In the event no date/event/or condition is specified, this consent expires one year from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release.

I understand that the information and records disclosed pursuant to this consent may be protected under 42 CFR Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR parts 160 and 164, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by the regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.

**The information I authorize for release may include records that may indicate the presence of a communicable or venereal disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).**

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 Signature of Consumer Date Witness (optional) Date

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 Signature of legal guardian, if required Date Relationship to consumer

**Next Steps:**

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| --- |
| To assess SOAR eligibility, we are looking for basic information on:* The presence of medical and/or psychiatric conditions or symptoms which would fit an SSA listing
* Current treatment or a history of treatment for conditions
* Inability to work and earn SGA ($1,550/month in 2024) due to medical and/or psychiatric conditions (not because they cannot find work or were laid off)
* Impairments in functioning due to medical and/or psychiatric conditions
 |
| ***SOAR specialists will contact the candidate to follow up on information provided on this form. A full intake assessment may be required to gather additional supporting evidence to determine if we can assist the candidate with a SOAR application.*** |

|  |
| --- |
| **TO BE COMPLETED BY SOAR COORDINATOR** |
|  |
|[ ]  Intake assessment is **NOT appropriate.** |
| Reason:  |
|[ ]  Candidate is **eligible for intake assessment** and will have: |
|  |[ ]  Initial appointment for screening scheduled for: | Click or tap to enter a date. |
|  |[ ]  Waitlist placement. Initial appointment to be scheduled at a later time. |
|  |
| Signature of SOAR Coordinator: |  | Date: |  |
|  |