SOAR Referral Instructions

It is important when making a SOAR referral that the referral is *complete* so that SOAR can accurately assess an individual's eligibility. Incomplete referrals will be sent back to the referral source for completion.

1. **SOAR Referral Form**
   - Complete all demographic and contact information
   - Section C: Include At-Risk Status/Homeless Status and History of Homelessness
   - Section E: Include location and length of treatment where indicated
   - Make sure the referral information at the bottom is completed. We will follow up once the referral has been received.
2. **Self Declaration of Income**
   - Required to verify client's current income source
3. **Release for Your Way Home**
   - This will serve as a blanket release to communicate with you, the referral provider, regarding the client. (If you have an agency release you would like to use, you may also submit that in addition to the YWH release).
4. **Data Release Form**
   - This serves as a release for SOAR staff to enter information into Your Way Home's secured Clarity HMIS Data System. This includes documentation of application status.
5. **SSA-1696 Form**
   - This is required for us to communicate with SSA regarding your referral
   - There is a template sample attached, in addition to a blank form, indicating where to have the client fill in their name, SSN, and where to sign.
   - **Please do not mark "X"s next to where the client needs to fill in their information.** This will void the form at the SSA office. We will require a new one if the form is marked up.

Please Note: Inpatient psychiatric facilities, mental health providers, hospitals, or ANY place that provides MH or medical services- must also include the following:

- A medical release from your facility
- All medical records-including progress/therapy notes, diagnoses, psychiatric evaluations and any other relevant documentation for the client for the duration of their stay (s) at your facility

We kindly ask that you do not give the referral forms to clients directly, referrals MUST come from a referral provider.

Completed referrals can be sent to the SOAR Team via e-mail.

Email: SOAR@vnacs.org

Updated: 1/29/24

SOAR Referral Form

Client's Name:		**Date of Birth:**	
Phone:		**SSN:**	
Gender:		**Race/Ethnicity:**	
Benefits Receiving:	SNAP Medicaid Medicare Other None		**Hispanic___ Not Hispanic___**
Address:		**Mailing Address:** *(if different)*	

A. List of Mental Health Diagnoses:		

B. List of Physical Diagnoses:		

C. Housing Status:	**Length/History of Homelessness (or at risk of) :**
Street Homeless___ Shelter___ Renting with subsidy ___ Renting without subsidy____ At-Risk/Other (explain)____:	

E. Please mark if client is currently in active mental health treatment.

- ☐ Yes **Where the client being treated at: _____ Length of treatment: _____**
- ☐ No

F. Individual is currently exhibiting the following symptoms of mental illness(es)

- ☐ Psychotic Symptoms
- ☐ Depressive Symptoms (decreased energy, lack of motivation, suicide attempts)
- ☐ Manic Symptoms (racing or disorganized thoughts)
- ☐ Anxious Feelings (paranoia, nervousness)
- ☐ Cognitive Deficits (brain injury, problems with concentration, memory, etc.)
- ☐ History of Trauma (history of abuse, post traumatic stress disorder, etc.)
- ☐ Other_____

G. For Applicants with a mental illness, do they experience restriction in the following functional areas (Check all that apply-This is needed to support client's level of disability)

- ☐ Activities of daily living (personal hygiene, cooking, cleaning, navigating transportation)
- ☐ Social Functioning (getting along with others, anger, avoidance, etc.)
- ☐ Concentration, persistence, and pace (do they have trouble completing tasks in these areas?)
- ☐ Repeated Episodes of Decompensation (hospitalizations, incarcerations, losing jobs/housing, etc.)

Referring Agency:		**Date Submitted:**	
Referral's Name:		**Phone Number:**	
Email:		**SOAR NOTE:**	
Please submit completed referral to:	**SOAR Benefit Specialist** **SOAR@vnacs.org or Fax 610-292-9160**		

Updated 1/29/2024

Your Way Home Partner Agency Logo

YOUR WAY HOME
MONTGOMERY COUNTY

Homeless Prevention and Rapid Re-Housing Program (HPRP)

SELF-DECLARATION OF INCOME

HPRP Applicant Name: _____

This is to certify the income status for the above named individual. Income includes but is not limited to:

- The full amount of gross income earned before taxes and deductions.
- The net income earned from the operation of a business, i.e., total revenue minus business operating expenses. This also includes any withdrawals of cash from the business or profession for your personal use.
- Monthly interest and dividend income credited to an applicant's bank account and available for use.
- The monthly payment amount received from Social Security, annuities, retirement funds, pensions, disability and other similar types of periodic payments.
- Any monthly payments in lieu of earnings, such as unemployment, disability compensation, SSI, SSDI, and worker's compensation.
- Monthly income from government agencies excluding amounts designated for shelter, and utilities, WIC, food stamps, and childcare.
- Alimony, child support and foster care payments received from organizations or from persons not residing in the dwelling.
- All basic pay, special day and allowances of a member of the Armed Forces excluding special pay for exposure to hostile fire.

Check only one box and complete only that section

☐ I certify, under penalty of perjury, that I currently receive the following income:

Source: _____ Amount: _____ Frequency: _____
Source: _____ Amount: _____ Frequency: _____
Source: _____ Amount: _____ Frequency: _____

HPRP Applicant Signature: _____ Date: _____

☐ I certify, under penalty of perjury, that I do not have any income from any source at this time.

HPRP Applicant Signature: _____ Date: _____

HPRP Staff Verification

I understand that third-party verification is the preferred method of certifying income for HPRP assistance. I understand self declaration is only permitted when I have attempted to but cannot obtain third party verification.

Documentation of attempt made for third-party verification:

_____

_____

HPRP Staff Signature: _____ Date: _____

Client's Authorization for Your Way Home Release

CLIENT NAME: _____

BIRTH DATE: _____

Consent to Release and Obtain Information To:	
Recipient:	**Your Way Home - Montgomery County** 1430 DeKalb Street, 5th FL Norristown, PA 19401 610-278-3826
Recipient:	**SOAR Program Team (Rebekah Jentes and Katie Lundy)** Visiting Nurse Association-Community Services 215-572-7880 x118

The following information will be released and obtained between said parties:

☐ Medical History (Including any diagnosis and appointments)
☐ List of Medications
☐ Mental Health History
☐ Demographic Information
☐ Employment History
☐ Any medical information to complete an SSI/SSDI application
☐ Other: _____

- By signing below I understand that the sole purpose of this release is to gather information to complete and submit an SSI/SSDI application.
- I also understand that authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization. Unless otherwise revoked, this authorization will expire when service by VNA-Community Services, Inc. is terminated.

This form has been fully explained to me and I certify that I understand its contents.

***Signature of client or responsible party:**	**Date:**

*If a person who is physically unable to provide a signature desires to consent to this release, print his or her name on the appropriate line above and record below the signature of a responsible person who witnesses that such person understands the nature of this release and freely gave his or her consent.

Witness:	**Date:**

Reason Client was unable to sign: _____

Your Way Home Montgomery County Data Systems
Release of Information

For: _____ **Date of Birth:** _____
(Print First, Middle, Last Name)

If you permit it, this agency may share limited information about you with other Your Way Home Montgomery County (YWH) agencies from who you may also seek services.

Please check (√) a box:

☐ This agency may share my personally-identifying information within YWH Data Systems

☐ Please treat information about my children age 17 or younger the same as mine:

Names: _____

Please be aware that we may also share the following information:

- Services you receive
- Your income
- Referral status for housing services
- Military history
- Living situation and housing history
- Your housing plan

☐ This agency may not share my personally-identifying information within YWH Data Systems

When you sign this form, it shows that you understand the following:

- We will not deny you help if you do not want us to share your personally-identifying information.
- Persons with access to YWH Data Systems are trained in security protocols to protect your data and are only permitted to view your data when you are specifically working with their agency.
- If you request services from another YWH agency, your information will be shared for referral purposes only
- YWH may use information derived from your data to create reports to share with funders, the community, and partners to better understand the scope of homelessness and the services being provided. Your personally-identifying information will never be used on these reports.

Signature of client or guardian _____ Date _____

Signature of agency representative _____ Date _____

Agency Use Only: YWH Code _____

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part I

CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this individual, 1109 Dekalb Street Norristown, PA 19401
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II(RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

_____
(Name of Principal Representative)

Signature (Claimant)	Address 1109 Dekalb Street Norristown, PA 19401	
Telephone Number (with Area Code) 215 572 7880	Fax Number (with Area Code) 610 292 9160	Date

Part II

REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, _____ , hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.

☒ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☒ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☒ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address 1109 Dekalb Street Norristown, PA 19401	
Telephone Number (with Area Code) 215 572 7880	Fax Number (with Area Code) 610 292 9160	Date

Part III

FEE ARRANGEMENT

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits —I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** —By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☒ **I am waiving fees from any source** —I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
PRINT CLIENT NAME	Client SSN
Wage Earner (If Different)	Social Security Number

Part I CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this individual, Rebekah Jentes, 1109 Dekalb Street Norristown, PA 19401
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☒ Title II(RSDI) ☒ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☒ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

(Name of Principal Representative)

Signature (Claimant)	Address 1109 Dekalb Street Norristown, PA 19401	
Client Signature		
Telephone Number (with Area Code) 215 572 7880	Fax Number (with Area Code) 610 292 9160	Date

Part II REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, Rebekah Jentes, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.

☒ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☒ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☒ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address 1109 Dekalb Street Norristown, PA 19401	
DO NOT SIGN HERE		
Telephone Number (with Area Code) 215 572 7880	Fax Number (with Area Code) 610 292 9160	Date

Part III FEE ARRANGEMENT

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits —I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** —By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☒ **I am waiving fees from any source** —I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date
DO NOT SIGN HERE	