Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR)

Requirement: Contract

Frequency: Monthly Reporting of SOAR data

Due Date: N/A

The purpose of this document is to provide guidance for the implementation and administration of the evidence-based SOAR model.

I. GOAL

The evidence-based SOAR model is designed to increase access to SSI/SSDI for eligible adults and children with mental illnesses who are experiencing or at risk of homelessness. The goal of the SOAR project is to advance resiliency and recovery for individuals and families through the income and health care benefits that SSI/SSDI provides. The Social Security Administration (SSA) administers two programs that provide income benefits to those who suffer from disabling conditions that impede their functioning and impact their ability to work.

- **Supplemental Security Income (SSI)**: Needs-based program for adults or children who are blind, disabled, or elderly, with low income/resources/ Florida Medicaid automatically accompany SSI benefits.
- **Social Security Disability Insurance (SSDI)**: Program for blind or disabled adults who are insured through employee and employer contributions to the Social Security Trust Fund

Economic stability is a social determinant of health and poverty correlates with barriers to health care and stable housing. Individuals experiencing or at risk of homelessness and living with disabling mental illnesses, co-occurring substance use, trauma, and/or other medical issues face multiple challenges which can impede access to the income and health care benefits that SSI/SSDI provides. SOAR works to overcome these barriers. Case Workers take the web-based SOAR Online Course to learn how to effectively gather documentation and submit a complete and thorough SSI/SSDI application packet to SSA. SOAR caseworkers collaborate with stakeholders and agree on a SOAR Process which establishes protocols for the submission and processing of SSI/SSDI applications. The State and Local SOAR Team Leaders support SOAR-trained case managers and keep stakeholders engaged.

II. Eligibility

SOAR assistance will be provided to adults or children who are receiving Department-supported substance abuse and mental health-funded services and are experiencing or at risk of homelessness.

III. Documentation Requirements

Admissions and Discharge

All SOAR admissions are voluntary and require consent and participation.

The Network Service Provider shall maintain the following clinical documentation for individuals served in the program.

Intake Documentation Requirements

The file contains basic demographic information, which includes (1) Client's name, (2) address, (3) telephone number, (4) marital status, (5) sex, (6) legal status, (7) race, (8) date of birth, (9) guardian contact information for minors, (10) referral source and (11) staff name of who has responsibility of the client.

The file contains, if applicable, a time-specific statement authorizing release of confidential information, signed, and dated by the client or guardian, which designates the agency to receive the information, purpose of the disclosure, how much and what kind of information to be disclosed, statement that the consent if subject to revocation at any time and date which consent will expire if not revoked before.

Assessments/Examination Documentation Requirements

The SOAR assessment is completed within 30 days after intake and includes the following with client input: (1) presenting problem, (2) current and potential strengths and problems, (3) relationship with family members and significant others, (4) service agencies with whom the client has been involved and involvement or need for involvement in social support systems.

Service/Treatment Planning

The SOAR service/treatment plan is completed 30 days after intake with the following goals and objectives with client input: (1) Achievable observable measurable, (2) reasonable timeframe, (3) actions needed to attain the goals and staff responsible, (4) incorporate needs and strengths from the assessment and (5) goals for each identified issue.

Progress Notes Requirements

Progress notes shall be prepared at least monthly for clients having a service/treatment plan unless documented otherwise.

Progress notes contain the (1) client's name, (2) client identification number, (3) staff name, (4) service date, (5) service duration, (6) a description of the service provided, (7) progress, or lack thereof, relative to the service/treatment plan or modified service/treatment plan from changes in client's needs, resources, or findings.

Progress note content must address SOAR activities.

Discharge/Termination Requirements

If no contact over 90 days, file must be closed, unless service/treatment plan indicates less frequent contact. The reason for the discharge/termination must be included.

Discharge/Termination report must be in the client record within 4 weeks after the termination of services.

Discharge/Termination report shall include the following: Evaluation of impact of agency's services on client's goals/objectives, date and signature of individual preparing report, if there is a referral and a reason for the referral must be noted.

IV. Network Service Provider Responsibilities

1) If the network service provider offers adult mental health general revenue case management services and/or adult and children mental health general revenue case management under the LSFHS contract, the provider shall employ one full-time employee to be utilized as a dedicated SOAR processor whose sole duty is to process SOAR applications for SAMH clients. Documentation of the processor's SOAR training will be maintained in the personnel file.
2) Network Service Providers shall adhere to the service delivery and reporting requirements herein.
3) Participate in local planning team that includes representatives from the local Social Security Administration, the Florida Department of Health Division of Disability Determinations, Network Service Providers, Continuums of Care, and other stakeholders serving this population. Local planning team activity includes:
    a. Developing an action plan to implement or expand the SOAR process consistent with the state initiative,
    b. Convening regular local planning team meetings to explore and identify strategies for ongoing funding and sustainability,
    c. Disseminating meeting minutes to the local planning team and the STL,
    d. Reporting implementation progress and challenges to the STL and the statewide SOAR Stakeholders Committee, and
    e. Coordinating and follow-up on implementation of the action plan through its Network Service Providers.
4) Annually complete a minimum of 25 SOAR-assisted applications for each full-time dedicated SOAR specialist or achieve a negotiated minimum quarterly target for completed SSI/SSDI applications for each part-time SOAR specialist that is determined and agreed on by both the Managing Entity and Network Service Provider.
5) Complete all SSI/SSDI applications within 60 days of the protective filing date, defined as the time when an applicant first contacts the Social Security Administration indicating an intent to file for SSI/SSDI.
6) Complete the appeal process for those applications which may be denied upon initial review when applicable.
7) Enter 100% of SSI/SSDI application data and outcomes into the SOAR Online Application Tracking (OAT) program available at: https://soartrack.samhsa.gov/.
8) Assign a staff member responsible for data submission quality control. This position shall ensure 100% of the following critical components are completed and reflected in OAT:
    - Completed SSA1696
    - Medical Records Collected
    - Medical Summary Report
9) Maintain a minimum completion rate of 75% of applications are completed and submitted to SSA within 60 days of the Protective Filing Date.
10) Maintain a minimum rate of 65% of submitted applications are approved on the initial submission.
11) Each SOAR processor will develop a best practice screening process to determine the best consumers to begin applications on behalf of. SOAR best practice tools can be located at: https://soarworks.samhsa.gov/content/library-home
12) Each SOAR application completed must have a Medical Summary Report.
13) Ensure SOAR training is completed using the SOAR Online Course and refresher trainings using the SOAR Online Course once every four (4) years for all SOAR staff. SOAR trainings for specifically

identified case managers and agency leads using the SOAR Online Course, are available at: https://soarworks.samhsa.gov/content/soar-online-course-catalog. A training on how to complete applications for children can also be completed at the following website. Completed child applications can be applied to successful outcomes on a case-by-case basis. Report data and outcomes to the RSTL and SOAR Technical Assistance Center using the Online Application Tracking (OAT) system, available at: https://soartrack.samhsa.gov/login.php?msg=10, including, but not limited to:

a. Number of SOAR-assisted SSI/SSDI applications.
b. Decisions on applications, including appeals; and
c. Numbers of days until applications are approved from date of application submission to date of decision.

14) Notify Network Manager when SOAR Processor has resigned from the agency.
15) SOAR Processors are required maintain individual medical records for each SOAR participant containing an intake form, a determination of eligibility for SOAR services, a SOAR service plan, and progress notes per 65E.4 guidelines as case management services will be the primary billing mechanism. If the SOAR program is part of a larger milieu of services, the consumer is participating in at a community provider the SOAR material must be integrated into that record.
16) Critical in addition to items in number 10 above, SOAR related documents must be deposited in the individual record and include the following (If applicable):
    a. SSA- 1696
    b. SSA- 827
    c. Agency ROI
    d. Copy of SSA-16 SSDI application
    e. SSA-8000 SSI application
    f. Medical Summary Report (Signed if possible)
    g. Medical Records
    h. Work History Report
    i. Function Report (If applicable)
    j. Third Party Function Report (If applicable)

Additionally, the Network Service Provider is required to:

1) Attend the regularly convened local planning team meetings to explore and identify funding and sustainability as well as develop a collaborative effort to implement the SOAR model in the region.
2) Sign up for a SOAR distribution list that will be organized by the ME for ongoing communication and dissemination of meeting minutes.
3) Report progress and challenges during regular meetings or by contacting the appropriate member of the ME staff if meetings cannot be attended by the provider. Providers are also encouraged to identify and address technical assistance needs as consistently as possible.

V. SOAR Training

The Adult/Child SOAR Online Course is the only acceptable training in Florida for new SOAR case workers, case workers whose initial SOAR training pre-dated the availability of the SOAR Online Course, or refresher trainings for case workers who have not completed SOAR-assisted applications in two years or more. The SOAR Online Courses are available at: https://soarworks.samhsa.gov/.

More information on SOAR can be viewed at https://soarworks.samhsa.gov/

Network Service Providers are encouraged to work closely to gain referrals from their Care Coordination departments, in house psychiatric departments, medical staff, case management, crisis stabilization units/detox services and homeless service Continuums of Care (CoC) providers to assist in locating and confirming consumers with a probable disability which limits or prohibits the ability to work for eligible adults either homeless or at risk of becoming homeless who have a serious mental illness, medical impairment, and/or a co-occurring substance use disorders.

As eligible and appropriate, it is expected that priority should be given to consumers identified and enrolled in Care Coordination as outlined in Incorporated Document 31-Care Coordination. It is recommended that the SOAR processors have established and make regular contact with the Care Coordination program(s)/person(s) at their agency, if applicable, to identify potential eligible clients to be prioritized for SOAR.

SOAR will be administered according to DCF Guidance 9, which can be found at following link using the applicable fiscal year: https://www.myflfamilies.com/services/samh/samh-providers/managing-entities