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. The Network Service Providers shall adhere to the service delivery and reporting requirements outlined herein.

I. Goal

The evidence-based SOAR model is designed to increase access to SSI/SSDI for eligible adults and children with mental health conditions who are experiencing, or at risk of, homelessness. The goal of the SOAR project is to promote resilience and recovery by connecting individuals and families to critical income and health care benefits. These benefits are provided through two programs administered by the Social Security Administration (SSA) which offer financial assistance to individuals whose disabling conditions limit their daily functioning and 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 key domain of health and poverty is closely linked to limited access to health care and stable housing. Individuals experiencing or at risk of homelessness, living with serious mental illnesses, co-occurring substance use, trauma, or other medical conditions, often face significant barriers access the income and health care benefits available through SSI/SSDI.

Through the SOAR Online course, case workers receive training on how to collect essential documentation and prepare comprehensive SSI/SSDI application packets for submission to the Social Security Administration. SOAR case workers also collaborate with local stakeholders to develop a coordinated SOAR process, which outlines protocols for submitting and processing applications. The SOAR State Team Lead (STL) and Local SOAR Team Leaders provide ongoing support to trained case managers help maintain active engagement among community partners.

II. Eligibility

SOAR assistance may be provided to individuals who:

- Adult or Child;
- Receiving substance abuse and mental health-funded services; and
- Experiencing or at risk of homelessness

III. 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. 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. The responsibilities of the local planning team include:
    a. Develop an action plan to implement or expand the SOAR process in alignment with the statewide initiative.
    b. Convene regular meetings to identify strategies for ongoing funding and sustainability.
    c. Disseminate meeting minutes to all the local planning team members and the STL.
    d. Report progress and challenges related to implementation to the STL and the Statewide SOAR Stakeholders Committee.
    e. Coordinate and follow-up on the execution of the action plan through Network Service Providers.
3. Participate actively in meetings and activities of the SOAR Stakeholders Committee.
4. Designated Network Service Providers shall meet the following performance expectations:
    a. Annually complete a minimum of 25 SOAR-assisted applications for each full-time dedicated SOAR specialist or meet a mutually agreed-upon quarterly target established by the Managing Entity and Network Service Provider.
    b. Submit all SSI/SSDI applications within 60 days of the protective filing date. The date an applicant first contacts the Social Security Administration to express intent to apply.
    c. Complete the appeal process for applications that are denied upon initial review when applicable.
    d. Ensure 100% of SSI/SSDI application data and outcomes are entered into the SOAR Online Application Tracking (OAT) program available at: https://soartrack.samhsa.gov/.
    e. Designate a staff member responsible for data submission quality control to verify that the following critical components are accurately completed and recorded in OAT:
        - Completed SSA1696 (Appointment of Representative)
        - Medical Records Collected
        - Medical Summary Report (MSR)
    f. Maintain a minimum completion rate of 75% of applications are completed and submitted to SSA within 60 days of the Protective Filing Date.
    g. Maintain a minimum rate of 65% of submitted applications are approved on the initial submission.

5. SOAR local lead shall be responsible to monitor and ensure accurate data input by Network Service Providers in the (OAT) program.

IV. 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/.

V. 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.

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