SOAR Program Referral Application

Partners Ending Homelessness

SOAR Program (Partners Ending Homelessness) Eligibility:

- Referred Client MUST be entering or currently in a HUD or CoC grant funded Permanent Supportive Housing Program.
- Must reside in Monroe County
- Obtaining or currently has a stable address to receive mail

***Please note: If a Client is being discharged from their PSH Program, they are not eligible for this SOAR Program. If the Client gets discharged while working with the SOAR Specialist, they will also be discharged from the SOAR Program. If an application or appeal is already submitted, the Client will receive assistance until a decision from the Social Security Administration (SSA) has been made.

To assess SOAR eligibility, we are looking for basic information on:

- The presence of medical and /or psychiatric conditions or symptoms which would fit a Social Security Administration (SSA) listing
- Current treatment, or a history of treatment for conditions (at least 12 months, preferably between 1-5 years).
- Inability to work and earn Substantial Gainful Activity (SGA) ($1,690/month in 2026) 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

***Please Note: Client must be in good standing within a PSH Program with no upcoming discharge and have official diagnoses from a Medical Care Provider.

Please complete in full and submit to:

Fax - (585) 625-0212 or Email - tbrugge@letsendhomelessness.org

If eligible, the SOAR Specialists will contact the client to follow up on the information provided on this form. A full intake assessment may be required to gather additional supporting evidence to determine if we can assist the client with a SOAR application.

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Client Name: _____ Date of Referral: _____

Referring Program/Agency: _____

Referring Staff: _____

Staff/Agency Contact Number: _____

Staff/Agency Email: _____

Client Contact Number/Email: _____

Client Identifying Information:

DOB: _____ Gender: _____ Pronouns: _____ Race: _____
(must be within 30 days of 18 years of age, or within 180 days if exiting foster care)

SSN: _____ Grade Level Completed: _____ Marital Status: _____

Current Living Arrangements (Address, Shelter, etc.): _____

Employment Status: _____ Full time/Part time (circle one)
If Unemployed, Date of last employment: _____ Full time/Part time (circle one)

Veteran: _____ Branch of Service: _____ Discharge Status: _____

Emergency Contact Name/Number/Relationship to Client:
_____

Part A: Homelessness/At-Risk Assessment

****Please note: Client must be able to maintain communication and have a stable address to receive SSA mail throughout this process*

Where is the candidate currently living? Check the appropriate selection

Homeless:
___ Place Not Meant for Habitation __ Shelter ___ Transitional Housing

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At-Risk of Homelessness:

____ Received an eviction notice or owes back rent/utilities ____ Exiting Foster Care
____ Permanent Supportive Housing that is grant-funded
____ Institution (Hospital, nursing home, rehab, etc.) ____ Jail/ Prison

If homeless, how long has the client been homeless: ____ Year(s) ____ Month(s)

Is the client in an institution or jail? Y/N
If yes, are they expected to be released within 30 days? Y/N
Were they experiencing homelessness before entering the facility? Y/N
Will they be in a Permanent Supportive Housing Program upon release? Y/N

Has the client had difficulty maintaining housing? Y/N
If yes, please describe: _____
_____
_____
_____

Part B: Current Application for SSA Benefits or Pending Appeal

Has the client recently applied for Social Security benefits? Y/N
If yes, date of application: _____ Decision on application: Pending/Denied
If denied, did the client appeal? Y/N
If yes, are they waiting on a decision? Y/N
Are they working with a lawyer? Y/N

Part C: Diagnostic Information

Please list all official mental health diagnoses: _____
_____
_____
_____

Please list all official physical health diagnoses: _____
_____
_____
_____

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Please list all relevant unofficial official mental and physical health diagnoses: _____

_____

_____

_____

Where has the candidate been treated for these conditions (official and unofficial)? _____

_____

_____

_____

Date of last doctors visit: _____

Does the client have a history of substance use? Y/N

If yes, is the client currently using? Y/N

Is the client currently being treated or has been treated in the past? Y/N

If so, where (Rehab, Inpatient, Outpatient, etc.): _____

Part D: Medical Providers (Use back of page it necessary)

Primary Care Providers, Mental Health Providers, Substance Use Counselors, Health Home Care Managers, Specialists, etc.

***Please Note: The longest and most difficult part of the application process is contacting Medical Providers and obtaining Medical Records. Having the following information upon referral will significantly help and quicken the referral/application process. Providing this information will also help the SOAR Specialist identify whether your client qualifies for the SOAR Program.

Facility	Treatment Provider	Dates Accessed	Conditions Treated

Part E: Other Information (Optional)

***Please Note: While optional, providing this information is extremely helpful for determining eligibility and the Functionality Reports in the SSI/SSDI Application process.

Client Income (DHS, SNAP, Child Support, etc.): _____

_____

Family in Household Currently Living with Client (Name/Age/Relationship): _____

_____

_____

Why is the Client looking to apply for Social Security Benefits? _____

_____

_____

Case Manager/Staff Observations of the Clients ability to:

Understand/Remember	
Interact with others	
Concentrate, make progress/complete tasks	
Adapt to situations, manage situations appropriately	

Remarks

(This space can be used for any additional remarks, explanations, or other extended comments from previous sections. Please enter the Part number if this space is being used for extended information).