Applicant Information

Applicant Name:_____ Applicant SSN:_____

Applicant DOB:_____
MMDDYY

THIS SECTION TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION

____ No Record ____Supplemental Security Income ____Social Security Disability Income

____Terminated Record ____SSI ____SSDI Date Terminated:_____
MMDDYY

Current Claim Status

_____SSI Claim Pending:
Initial Claim Date Filed:_____
Reconsideration Date Filed:_____
Hearing Level Date Filed:_____

_____SSDI Claim Pending:
Initial Claim Date Filed:_____
Reconsideration Date Filed:_____
Hearing Level Date Filed:_____

_____SSI Claim Denied:
Initial Claim Date Denied:_____
Reconsideration Date Denied:_____
Hearing Level Date Denied:_____

_____SSDI Claim Denied:
Initial Claim Date Denied:_____
Reconsideration Date Denied:_____
Hearing Level Date Denied:_____

(Circle One)
SSI Denial Reason: Medical Non-Medical Other **SSDI Denial Reason:** Medical Non-Medical Other
Other (If circled Other above, please explain): _____

Allowance

____SSI
Eligibility Date:_____

____SSDI
Eligibility Date:_____

SSA Claims information was provided by: _____
(SSA Staff)

Date of Response:_____

Telephone Number:_____ SSA Field Office Code:_____

Please Return Form To:

SOAR Caseworker:_____

Fax Number:_____ Phone Number:_____