Application Tracking Worksheet for Child SSI Applications

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| **SOAR Online Application Tracking (OAT) ID#:** | | | | | | |  | | | | | | |
|  | | | | | |  | | | | | | | |
| **Contact Information** | | | | | | | | | | | | | |
| **Child’s Name:** | | | | **DOB:** | | | | | | | | **SSN:** | |
| **Phone:** | | | **Address:** | | | | | | | | | | |
| **Identifying Information** | **Birthplace (city, state):** | | | | | | | | | | | | |
| **Parent(s)/Legal Guardian(s) Name(s):** | | | | | | | | | | | | |
| **Third Party Contact**  *(if applicable)* | **Name:** | | | | | | | | | | | | |
| **Phone:** | | | | | | | | | | | | |
| **Address:** | | | | | | | | | | | | |
| **Area of town where child/child’s family stays:** | | | | | | | | | | | | | |
| **Food kitchens/shelters/etc.:** | | | | | | | | | | | | | |
| **Other staff/programs involved:** | | | | | | | | | | | | | |
| **Program/Staff Contact:** | | | | | | | | | | | | | |
| **SSA Information** | | | | | | | | | | | | | |
| **Protective filing date: / /** | | | | | | | | | | | | | |
| **Online Disability Report submission date: / /** | | | | | | | | | | | | | |
| **SSI Application submission date: / /** | | | | | | | | In Person By Phone | | | | | |
| **Date of onset provided on the application: / /** | | | | | | | | | | | | | |
| **SSA Claims Representative Name:** | | | | | | | | | | | **Phone:** | | |
| **Office address:** | | | | | | | | | | | | | |
| **SOAR Critical Components** | | | | | | | | | | | | | |
| **SSA-1696 Appointment of Representative form submitted?** | | | | | | | | | | Yes | | | No |
| **Medical evidence submitted with application?** | | | | | | | | | | Yes | | | No |
| **Medical Summary Report (MSR) submitted with application?** | | | | | | | | | | Yes | | | No |
| **MSR co-signed by an Acceptable Medical Source (AMS)?** | | | | | | | | | | Yes | | | No |
| **Quality review of application before submission?** | | | | | | | | | | Yes | | | No |
| **If yes, who conducted the quality review?** | | | | | | | | | | | | | |
| **DDS Information** | | | | | | | | | | | | | |
| **DDS Disability Examiner Name:** | | | | | | | | | | **Phone:** | | | |
| **Dates of follow-up contact with DDS examiner:** | | | | | | | | | | | | | |
| **Consultative examination appointment?** | | | | | Yes | | | | No | If yes, date: | | | |
| **Outcome and Follow-up** | | | | | | | | | | | | | |
| **SSI Date of decision: / /** | | Denied | | | | | | Approved | | Amt. awarded: $ | | | |
| **Reconsideration/Appeal filed** (N/A if person is approved): | | | | | | | | | | | | | |