PDS-SOAR Program Eligibility Screening

Client Eligibility SOAR is a service to help individuals apply for or maintain Social Security disability benefits if they are both: (1) homeless or at risk of becoming homeless and (2) have a disability.

Step 1: Homelessness or Housing Status
Do you meet at least one of the following housing situations?

1. Are you currently homeless (e.g., living outdoors, in a shelter, or in an abandoned/condemned building)?
   ☐ Yes ☐ No
2. Are you at risk of becoming homeless (e.g., staying with others without being on the lease, received an eviction notice, in a halfway house, in transitional housing, etc.)?
   ☐ Yes ☐ No
3. Are you living in permanent supportive housing designed for individuals who have experienced homelessness?
   ☐ Yes ☐ No

2: Disability Requirement

4. Do you have a documented physical or mental health condition expected to last more than one year or result in death?
   ☐ Yes ☐ No

5. Does this condition significantly limit your ability to work or carry out daily activities?
   ☐ Yes ☐ No

Step 3: Age Requirement

6. Are you under the age of 65?
   ☐ Yes ☐ No

If you are over 65, you may receive assistance from PDS SOAR advocate. PDS SOAR advocate can help you connect with SSA & set up appointment to complete your application. Please consult with PDS SOAR program coordinator for guidance.

Step 4: Residency

7. Do you currently live in Minnesota?
   ☐ Yes ☐ No

Eligibility Summary

- If you answered **"Yes" to Questions 1, 4, 5, 6, and 7**, and at least **one** of Questions 1–3: You likely meet the SOAR eligibility criteria.

- If you answered **"No" to any required question**, or are **over age 65**, please reach out to the program coordinator to discuss alternative options.

  Name:_____ Date:_____

  For office Use Only:

  Name of the PDS SOAR Coordinator: _____

  Appointment/Walk-in Date:_____

Instructions for Completing Form SSA-1696

Keep a copy of this form for your records

DO NOT FILE form SSA-1696 if you do not have a claim, you are not filing a claim with this form, or there is no other issue pending decision with us. *In this document, "you" means the claimant, beneficiary, auxiliary or spouse. "Us" and "SSA" means the Social Security Administration.*

General Information About This Form

- You have the right to appoint a qualified representative of your choice to represent you on any claim or asserted right under any of our programs. For more information on who can qualify to be an appointed representative, when your representative's appointment begins or ends, payment of fees to appointed representative(s), and other helpful information, or to locate your local field office, you can visit our website at www.ssa.gov/locator. Call us, toll-free, at 1-800-772-1213.
- You and your representative(s) may use this form to start the representation. Your representative may also use this form to waive a fee, waive direct payment of the fee, or tell us that a third party will pay the fee.
- You may also choose to be unrepresented. We handle your case in the same manner whether you are represented or unrepresented. You do not need to appoint someone who simply helps you through the process. For example, you do not need to appoint someone who helps you come to our office, reads to you from documents, or interprets for you if you speak another language. You only need to appoint someone if he or she will be acting or appearing on your behalf, or will be making decisions about your case for you.
- You and your representative(s) must give us accurate information as quickly as possible. Providing misleading or false evidence on this form or your application, or withholding or delaying giving us evidence, could lead to possible criminal charges or administrative sanctions against you or your representative.

Appointing a Representative

If you are using this form to appoint a representative, you must complete Sections 1, 2, and 3. Your representative must complete Sections 5 and 7 of this form. Both you and your representative must complete Section 4, either of you can complete section 6. You or your representative must file the completed form with us, in-person at your local field office, by mail, or by fax. Review and complete all required sections. If you are appointing multiple representatives, use separate forms for each representative. Your representative or someone else can help you complete the form but you must sign and date Section 8. Your representative must also sign the form if he or she is a non-attorney. You or your representative must submit the completed form to us before we will recognize your representative. You can file it in-person at your local field office, mail it, or fax it to us. Do not file this form with your local State Disability Determination Services office.

Section 1 - Claimant's Information and Number Holder's Information

Complete all of the information, including your Social Security Number. If you are filing your claim on someone else's Social Security record, this person is the "number holder" and we need his or her information to process your claim.

Section 2 - Authorization for Disclosure

By selecting the disclosure box, you are authorizing us to give information to your representative's staff, partners, associates and other individuals who work for or with your representative (such as contractors and copying services). We will check the credentials of the individuals requesting information on behalf of your representative for authentication purposes.

Section 3 - Principal Representative

If you appoint or have appointed multiple representatives, you must name your principal representative who will be our main point of contact. We will send copies of your notices to this individual and communicate directly with him or her.

Section 4 - Representative's Information

Both you and your representative must complete all of the information in this section. It is important to fill in all the boxes, including the Representative Identification Number (Rep ID). Ask your representative for his or her Rep ID, if you do not know it. This box should only be left blank if your representative does not have a Rep ID.

Section 5 - Representative's Status, Affiliations, and Certifications

Your representative must complete this section to let us know his or her status as a professional. If your representative is seeking a fee and is working for an employer, entity or firm, he or she must also complete the affiliation section and give us the Employer's Identification Number (EIN). We will provide both your representative and the employer, entity, or firm with a copy of the form IRS 1099-MISC showing the reported income. For more information on form 1099-MISC and employer registration, visit our website at www.ssa.gov/representation. Your representative should also certify the accuracy of all statements in this section.

Section 6 - Claim Type

Either you or your representative can complete this section. Check all types of claims for which you seek representation.

Section 7 - Fee Arrangement

Complete this section, if your representative is or will be asking for a fee for services performed on your claim. Generally, to charge a fee for services, your representative must get our approval. Your representative may waive the right to charge you a fee or tell us that a third party entity (business, government agency, or organization) will pay the fee. In these situations, the third party must pay out of its own funds the fee and any expenses, and you and any auxiliary beneficiaries (e.g., children or spouse) must be free of responsibility to pay any fees or expenses. If your representative is eligible for direct payment, he or she also may waive the right to direct payment.

Section 8 - Signatures

You must sign and date this section. If your representative is not an attorney, he or she also must sign and date this section. We also encourage attorneys to sign this section to confirm that they will abide by our rules.

Privacy Act Statement - Collection and Use of Personal Information

Sections 206 and 1631(d) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from appointing a representative to act on your behalf.

We will use the information to verify the appointment of your representative and his or her acceptance of the appointment. We may also share your information for the following purposes, called routine uses:

- To a congressional office in response to an inquiry from that office made on behalf of, and at the request of, the subject of the record or a third party acting on the subject's behalf;
- To Federal, State, and local law enforcement agencies and private security contractors, as appropriate, information necessary:
  - (a) to enable them to protect the safety of Social Security Administration (SSA) employees and customers, the security of the SSA workplace, and the operation of SSA facilities; or
  - (b) to assist investigations or prosecutions with respect to activities that affect such safety and security or activities that disrupt the operation of SSA facilities; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders Systems, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784; 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210; and 60-0325, entitled Appointed Representative File, as published in the FR on October 8, 2009, at 74 FR 51940. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. You may send us your comments on our estimated completion time to **SSA, 6401 Security Blvd., Baltimore, MD 21235-6401**. Send only comments relating to our time estimate to this address, not the completed form.

References

- 18 U.S.C. §§ 203, 205, and 207; 42 U.S.C. §§ 406, 1320a-6, 1383(d)(2) and 1631;
- 26 U.S.C. §§ 6041 and 6045(f) and 20 CFR §§ 404.1700 et. seq. and 416.1500 et. seq.

Claimant's Social Security Number

			-		-				
			-		-				

Appointed Representative's Rep ID

Claimant's Appointment of a Representative

Section 1 - Claimant's Information

First Name	Initial	Last Name

Mailing Address

City	State	ZIP/Postal Code	Country - if outside the U.S.

Phone Number		Alternate Phone Number (Optional)	
Country/Area Code	Phone Number	Country/Area Code	Phone Number

Number Holder's Information *(Complete when applicable)*

My claim is based on another person's work or earnings (e.g., spouse or parent). This person's information is different from mine.

Number Holder's Social Security Number

			-		-				
			-		-				

First Name	Initial	Last Name

Section 2 - Disclosure *(Claimant Only)*

☐ By selecting this box, I, the claimant listed in Section 1, whose signature appears in Section 8, authorize SSA to release information in relation to my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g., clerks, assistants), partners, or parties under contractual arrangements for or with my representative. *(The appointed representative's partners, associates, delegates and designees must be prepared to provide information in order to be authenticated.)*

Section 3 - Principal Representative *(Claimant only – Complete when applicable)*

I have appointed before, or appoint now, more than one representative. I ask SSA to make contacts or send notices to this individual. My principal representative is:

Name

Claimant's Social Security Number

			-			-				
			-			-				

Appointed Representative's Rep ID

Section 4 - Representative's Information *(Claimant and Representative)*

Representatives who are eligible and seek direct payment of their fee must register and receive a Rep ID before the appointment. For more information about registration visit us on-line at www.socialsecurity.gov/ar, contact us at 1-800-772-1213 (TTY 1-800-325-0778), or visit your local Social Security office.

First Name	**Initial**	**Last Name**

Mailing Address

City	**State**	**ZIP/Postal Code**	**Country - if outside the U.S.**

Phone Number		**Alternate Phone Number (Optional)**	
Country/Area Code	Phone Number	Country/Area Code	Phone Number

Section 5 - Representative's Status, Affiliations, and Certifications *(Representative Only)*

Representative's Status Part A - Type of Representative (Representatives have a duty to keep their information current)

☐ I am an attorney *(SSA law states that an attorney is someone in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)*

☒ I am a non-attorney eligible for direct payment *(SSA law requires that non-attorneys meet certain criteria to qualify for direct payment. Refer to our website at www.ssa.gov/representation for criteria).*

☐ I am a non-attorney not eligible for direct payment.

☐ I work for a non-profit organization (e.g. a law clinic or state legal aid)

Representative's Status Part B - Disqualification

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice law.

☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency.

☐ Yes ☒ No

Claimant's Social Security Number

Appointed Representative's Rep ID

Section 5 - Continued *(Representative Only)*

Affiliation Information

If you are representing the claimant(s) as a partner or employee of a business entity, firm or other organization you may provide your Employer Identification Number (EIN) here, if one exists for tax purposes. This number is not your Social Security Number (SSN). This is your employer's tax identification number. (*Do not complete this section if you do not qualify for direct payment.*)

EIN

Organization's Name (Enter the full name of the business, entity, firm or organization with which you want to be affiliated while representing this claim)

Peoples Development Services (PDS)

Representative's Business Address (if different than mailing address)

665 Snelling Ave N

City	State	ZIP/Postal Code
saint Paul	MN	55114

Country - if outside the U.S.

Representative's Certifications

I accept this appointment and certify the following:

- I understand and agree that I will comply with SSA's laws and rules on the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives; I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies.
- I understand that if I fail to comply with any of SSA's laws and rules I may be suspended or disqualified as a representative before SSA.
- I will not disclose any information to any unauthorized party without the claimant's specific written consent.
- I am not currently suspended or prohibited, for any reason, from practicing before the Social Security Administration.
- I am not disqualified from representing the claimant as a current or former officer or employee of the United States.
- I accept appointment as the representative for the claimant named in Section 2 of this form in connection with the claims and asserted rights described in Section 6 of this form.
- I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original.
- I declare under penalty of perjury that I have examined all of the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

If I intend to seek direct payment of the authorized fee on this claim -

- I have registered for and obtained a Rep ID, and my registration information is up-to-date.
- I have provided up-to-date information on my registration concerning whether I have been suspended or prohibited from practice before SSA or any other Federal program or agency, disbarred or suspended by a court or bar, and convicted of a violation under Section 206 or 1631(d) of the Social Security Act.

I CERTIFY TO ALL OF THE ABOVE *(Representative's Initials)*

Claimant's Social Security Number

			-			-				
			-			-				

Appointed Representative's Rep ID

Section 6 - Claim Type *(Claimant or Representative)*

I appoint the individual named in Section 4 to act as my representative in connection with my claim(s) or asserted right(s) under Title II (RSDI), Title XVI (SSI), Title XVIII (Medicare Coverage), and Title VIII (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (*Check all that apply*)

- ☐ Claim/Appeal for Title II Disability Benefits
- ☐ Claim/Appeal for Title XVI Disability Benefits
- ☐ Concurrent Title II and Title XVI Disability Benefits
- ☐ Claim/Appeal for Retirement Benefits
- ☐ Claim/Appeal for Title XVIII (Medicare), VIII (Special Veteran's Benefits)
- ☐ Continuing Disability Review (CDR)
- ☐ Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

_____

(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

Section 7 - Fee Arrangement *(Representative Only)*

Check one box below:

- ☐ **I will request a fee and direct payment of this fee**. Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. *(We must authorize the fee.)*
- ☐ **I will request a fee but not direct payment.** Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. *(We must authorize the fee.)*
- ☒ **I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual.** Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. *(We do not need to authorize the fee if all regulatory conditions apply.)*
- ☐ **I waive the right to a fee.**

Section 8 - Signatures *(Claimant and Representative)*

Representative's Signature	**Date**
Claimant's Signature	**Date**