Application Tracking Worksheet

Appointed Representative Rep ID#:	

Applicant Contact Information		
Name:	**DOB:**	**SSN:**
Email:	**Phone:**	
Residence Address/Location:		
Identifying Information *(useful when speaking with SSA)*	**Birthplace (city, state):**	
	Mother's Maiden Name:	
Third Party Contact *(if applicable)*	**Name:**	
	Phone:	**Email:**
	Address:	
Other agencies/programs involved:		

SSA Information		
SSA Claims Representative Name:		
Office address:		
Phone:	**Fax:**	**Email:**
Dates of follow-up contact:		

DDS Information		
Disability Examiner Name:		
Phone:	**Fax:**	**Email:**
Dates of follow-up contact:		
Consultative examination Date(s) (*if applicable):*		

Application Information		
Protective filing date (PFD): / /	**PFD set:** ☐ Online ☐ In Person ☐ By Phone	
Online Application Reentry #:	**Date of onset**: / /	
Application Submission Date	**Online**: / /	**Paper Packet**: / /

Evidence Submission Dates	
Medical records/evidence: / /	**Method:** ☐ ERE ☐ Bar-Coded Fax
Functional Assessment Statement (FAST) Medical Summary Report (MSR): / /	**Method:** ☐ ERE ☐ Bar-Coded Fax
FAST MSR reviewed prior to submission by: ☐ Supervisor ☐ SOAR Lead ☐ TA Center Liaison	
(If requested) **Function Report:** / /	**Work History Report:** / /

Outcome and Follow-up		
SSI Date of decision: / /	☐ Denied ☐ Approved	Amt. awarded: $
SSDI Date of decision: / /	☐ Denied ☐ Approved	Amt. awarded: $
If denied, Reconsideration/Appeal request filed on: / /		