SAIH PROGRAM INTERAGENCY COMMUNICATION FORM
For DHHS Approved Supported Housing Slots
IMC to LME Regarding Income Verification or SAIH Eligibility

☐ **Application** ☐ **Review** ☐ **Change**

From SA IMC (name): **Date:**

SA IMC Email: **County DSS:** **SA IMC Phone #**

Purpose of Communication:

IMC - SAIH /TCL ☐ Application ☐ Recertification ☐ Application # ☐PDC

Client Name: Medicaid ID #:

FL2 Needed: ☐Yes ☐No FL2 Expiration date: Date case decision is due:

Verification of Functional Assessment/Reassessment needed? ☐Yes ☐No Enhanced rate? ☐Yes ☐No

Is **DAAS-0032** *Signature Attestation Form* needed? ☐Yes ☐No (If yes, Signature Attestation Form attached)

IMC - ☐ Verification of Income

GROSS INCOME AMOUNT: $

NOTE (Revised 6-14-13): *DSS can provide the gross amount of the income regardless of the method of verification* ***with appropriate release of information****. The* ***source of income*** *can be provided only when verified through a method other than an electronic data match. (Electronic data matches include matches from the Social Security Administration, Veterans' Administration, Employment Security Commission, etc.)*

RSDI $ SSI $ VA $ OTHER $

IMC - ☐ Notification of SAIH / TCL Authorization

SAIH / TCL Certification Period: to Enhanced rate? ☐Yes ☐No

SAIH Approved Ongoing Amount $

SAIH Partial Month *(for cases* ***not*** *previously SA eligible in an ACH)* $

IMC ☐ Report of Change

Reported CHANGE:

Signature of DSS Worker: _____ **Date:**

Title: