The DAAS-SAIH PROGRAM INTERAGENCY REFERRAL FORM

☐ Application ☐ Review ☐ Change

To: ☐ **Adult Services Case Manager** ☐ **Income Maintenance Caseworker (IMC)**

Case Name: Client Phone #

Client Address: Client Medicaid ID#

IMC – SAIH Application **SAIH Application #** **SAIH Application Date:**

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

Income: RSDI $________ SSI $_______ VA $_______ Other $________ Eligible for $20 disregard? _______

SAIH approved? ☐Yes ☐No SAIH Certification Period: to Enhanced rate? ☐Yes ☐No

☐ Partial SAIH Payment Amount $ ☐ Ongoing SAIH Payment Amount $

IMC – SAIH Recertification **NC FAST SAIH PDC#**

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

Income: RSDI $________ SSI $_______ VA $_______ Other $________ Eligible for $20 disregard? _______

Enhanced rate? ☐Yes ☐No Continued SAIH eligibility: ☐Yes ☐No If 'No', payment ends:

SAIH Eligibility Recertification Period: to Ongoing SAIH Payment Amount: $

IMC – SAIH Change **NC FAST SAIH PDC #**

Reported Change: ____

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Income Maintenance Case Worker Signature: ______________________________ **Date:**

Adult Services Application Assessment/Recertification Reassessment completed Date:
If Assessment/Reassessment **not** completed, indicate action to be taken: ___________________________

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Assistance from the SAIH Program continues to be sufficient to allow client to safely remain at home.

Signed *DAAS-0032 Signature Attestation Form* attached ☐Yes ☐No Date:
If **'No'**, indicate action taken: ____

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Reported Change: ____

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SAIH Case Manager Signature: ________________________________ **Date:**