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: _____ **Date:** _____

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

Purpose of Communication:

IMC - SAIH /TCL ☐ **Application** (# _____) ☐ **Recertification** (# _____)

Case Name: _____ Medicaid ID #: _____

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

Verification of TCL eligibility (or continued TCL eligibility) by LME/MCO needed? ☐ Yes ☐ No

Individual eligible for Enhanced rate? ☐Yes ☐ No

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: _____