

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** **Application #** **PDC #**

Case Name:	Medicaid ID #:
FL2 Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	FL2 Expiration date: _____ Date case decision is due: _____
Verification of Functional Assessment/Reassessment needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Enhanced rate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(Note to LME/MCO: the referenced 'assessment/reassessment' is confirmation that your organization is currently working with or continues to work with the above case member. It MUST be supplied when requested. Follow instructions on the DSS-0034 Appendix E Suppl. 2 to confirm.)	

IMC - **Verification of Income**

GROSS INCOME AMOUNT: \$			
<i>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.)</i>			
RSDI \$	SSI \$	VA \$	OTHER \$

IMC - **Notification of SAIH / TCL Authorization**

SAIH / TCL Certification Period: _____ to _____	Enhanced rate? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____