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

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

Is signed *Signature Attestation Form* needed? ☐ Yes ☐ No (If yes, blank 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: _____