

SAIH PROGRAM INTERAGENCY COMMUNICATION FORM
For DHHS Approved Supported Housing Slots
LME to DSS Eligibility

Date:

Purpose of Communication:

- Report Change in Circumstance Information (ACH transition to Private Living)
- Request Gross Income Information
- Request SAIH Eligibility
- Release of Information is attached

From: LME/MCO Transition Coordinator

Name:

Title:

Phone Number:

Email address:

LME/MCO Name:

LME/MCO Mailing Address:

City & Zip Code:

To: DSS
(County Name)

CASE NAME:

Medicaid ID #:

- Functional Assessment/Reassessment (confirmation that LME/MCO *is currently working with or continues to work with* above referenced case member) completed Date:
(Note to LME/MCO: if there has been a change and your organization is no longer working with the case member, check "Other" below and explain date and circumstances of discontinuance of services.)
- Other

Details of client discharge from ACH (projected date & private living address client has will move to):

Report of Other Change

Reported CHANGE:

LMC/MCO Transition Coordinator Signature: _____

Date:

Title: