

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 completed Date:
- signed *Signature Attestation Form* is completed/attached Date:
If 'No', indicate action to be taken:
- 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: