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: