

The DAAS-SAIH PROGRAM INTERAGENCY REFERRAL FORM

Application Review Change

To: **Adult Services Case Manager** **Income Maintenance Caseworker (IMC)**

Case Name: _____ Client Phone # _____

Client Address: _____ Client Medicaid ID# _____

IMC – SAIH Application **SAIH Application #** **SAIH Application Date:**

FL2 Needed: Yes No FL2 Expiration date: _____ Date case decision is due: _____
Income: RSDI \$ _____ SSI \$ _____ VA \$ _____ Other \$ _____ Eligible for \$20 disregard? _____
SAIH approved? Yes No SAIH Certification Period: _____ to _____ Enhanced rate? Yes No
 Partial SAIH Payment Amount \$ _____ Ongoing SAIH Payment Amount \$ _____

IMC – SAIH Recertification **NC FAST SAIH PDC#**

FL2 Needed: Yes No FL2 Expiration date: _____ Date case decision is due: _____
Income: RSDI \$ _____ SSI \$ _____ VA \$ _____ Other \$ _____ Eligible for \$20 disregard? _____
Enhanced rate? Yes No Continued SAIH eligibility: Yes No If 'No', payment ends: _____
SAIH Eligibility Recertification Period: _____ to _____ Ongoing SAIH Payment Amount: \$ _____

IMC – SAIH Change **NC FAST SAIH PDC #**

Reported CHANGE: _____

Income Maintenance Case Worker Signature: _____ **Date:** _____

Adult Services Application Assessment/Recertification Reassessment completed Date: _____
If Assessment/Reassessment **not** completed, indicate action to be taken: _____

Assistance from the SAIH Program continues to be sufficient to allow client to safely remain at home.
Signed *DAAS-0032 Signature Attestation Form* attached Yes No Date: _____
If **'No'**, indicate action taken: _____

Reported CHANGE: _____

SAIH Case Manager Signature: _____ **Date:** _____