SA IN HOME PRE-SCREENING FORM

Section 1: SA/IH Referral Form

(To be completed by the referring DSS staff)

a) Department making the referral:
☐ Income Maintenance / ☐ Adult Services / ☐ Other:_____

b) Name and relationship of individual making the referral:
Name _____ Relationship _____

c) POA/Guardian if different than individual making referral: _____

Referral Information	**Slot #:**
Name:	Date of **SA/IH** application:
Physical address:	City:
Mailing address:	Zip:
Client has full CN Medicaid? ☐ YES ☐ NO	Medicaid ID #:
Does Client desire to remain in or move to a private living arrangement (PLA)? ☐ YES ☐ NO	If client is not currently in a PLA is one available? ☐ YES ☐ NO
Comments: (ie: date of projected move to PLA, explanation of current living arrangement and/or individual was/is currently receiving in another county)	

Section 2: Financial Evaluation and Medicaid Eligibility Verification

(To be completed by IMC:SAA apps maximum 45 days; SAD apps maximum 60 days expedited process for individuals with Supported Housing Slots under the Transitions to Community Living)

Case Name:	**NCFAST Income Support Case #:**
SA Medicaid eligible: ☐ YES ☐ NO	FL-2 Needed: ☐ YES ☐ NO If yes document date provided.
Gross Monthly Income/Mandatory Deductions (health Insurance, taxes, etc.)	
Gross Monthly Income: $	Monthly Income Deductions: $
Note: If the verification listed above is obtained from an electronic source (ie: SOLQI), the specific source of income cannot be provided. **Comments:**	

***NOTE:** If the client desires to apply for SAIH provide client with information on the FL-2 requirement and refer to Adult Services for additional referral and service information*

Section3: Referral to Adult Services for Assessment

Date of Referral to Adult Services	
IMC/CM Signature	Date: