ENRICHED RESIDENTIAL CARE CHANGE IN INCOME NOTIFICATION

Date: ________________

Enriched Residential Care (ERC) Program: ☐ **DHS** ☐ **DMH** **CHAMP/IBHIS ID:** __________

Instructions: *Complete all applicable sections and attach supporting documentation verifying the change in income within one business day.*

A. This Section to be Completed by the Facility Administrator:

Participant Information

First Name: ________________________ Last Name: ________________________________ DOB: ________________

Facility Information

Facility Name: ___________________________________ Phone: ______________________ Fax: ___________________

Address: ____ City: ___________________ Zip: __________ SPA: ___________

Type: ☐ Adult Residential Facility ☐ Residential Care Facility for the Elderly ☐ Skilled Nursing Facility ☐ Congregate Living Health Facility

Check all applicable boxes below and attach benefits award letter and/or income statement.

Previous Income Information

Income Source: ☐ Supplemental Security Income (SSI) ☐ Disability Income ☐ Social Security Retirement ☐ V.A. Benefits
☐ None ☐ Other, Specify: ____

Income Amount Per Month: $_________________ Income Stop Date: ____

Current Income Information

Income Source: ☐ Supplemental Security Income (SSI) ☐ Disability Income ☐ Social Security Retirement ☐ V.A. Benefits
☐ None ☐ Other, Specify: ____

Income Amount Per Month: $_________________ Income Start Date: ____

Reason for Income Change: ____
____

ICMS/CM Notified of Income Change? ☐ Yes ☐ No ICMS/CM Agency (If Known): ________________________________

ICMS/CM Staff Name: ____ Phone: ______________________________

Facility Administrator Name and Title: ____
Facility Administrator Phone No.: ____

B. This Section to be Completed by DHS/DMH ERC Staff:

Revised Payment Summary **Effective Date:** ______________________

Participant's Current Rent: $ __________________ **Participant's Proposed Rent: $** ____________________

	Monthly Rate	New Participant Contribution	New BC Subsidy Amount
Rent			
P & I			
Enhanced Services			
Total			

ERC Staff Name: ____ **Date Sent to Brilliant Corners:**_________________

ERC Staff Signature: ____ **Date:** ______________________

Return this form with the benefits award letter and/or income statement to DHS/DMH ERC.
For DHS ERC, email erc@dhs.lacounty.gov ***or fax to (213) 895-0106.***
For DMH ERC, email DMH_ERC@dmh.lacounty.gov or fax to (213) 637-2336.