LA COUNTY Homeless Services & Housing

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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# ENRICHED RESIDENTIAL CARE CHANGE IN INCOME NOTIFICATION

**Date:** _____

**CHAMP/IBHIS ID:** _____

**Enriched Residential Care (ERC) Program:** ☐ **HSH** ☐ **DMH**

***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

*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: _____

_____

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

MCW/CM Staff Name: _____ Phone: _____

**Facility Administrator Name and Title:** _____

**Facility Administrator Phone No.:** _____

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

**Revised Payment Summary** **Effective Date:** _____

**Current Basic Services: $** _____ (Rent + Care) **Proposed Basic Services: $** _____ (Rent + Care)

| | Monthly Rate | New Participant Contribution | New BC Subsidy Amount |
|---|---|---|---|
| Basic Services (Rent + Care) | | | |
| 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 HSH/DMH ERC.**

***For HSH ERC, email ERCinvoices@hsh.lacounty.gov.***
***For DMH ERC, email DMH_ERC@dmh.lacounty.gov or fax to (213) 559-9258.***

**Return this form with the benefits award letter and/or income statement to HSH/DMH ERC.**