DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

Monitored In-Home Caregiving (MIHC) Services Form

Name of Participant: _____

DOB: _____ Address: _____

Name of Personal Representative (if applicable): _____

Name of SCA: _____ Phone # of SCA: _____

Name of SC: _____

The following has been approved and Prior Authorization(s) (PAs) can be released for payment:

☐ **I. MIHC Intake & Assessment (T1028)** Amount authorized: $250.00

Name of MIHC provider: _____

Phone Number: _____

Date of Initial Contact by MIHC provider: _____

Completion Date of MIHC assessment: _____

Participant is MIHC eligible: ☐ Yes ☐ No

If yes, MIHC start date: _____

Signature of Support Coordinator: _____

SC Supervisor Signature: _____

Date: _____