Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™

Idaho Independent Assessment Services Program
8850 W. Emerald St. - Suite 164 | Boise, ID 83704 | 208.258.7980 | FAX: 208.258.7985 | EMAIL: idahoias@libertyhealth.com

Plan Developer Choice Form

Participant Name: DOB:

I choose the following plan developer and agency as my plan developer/agency/support broker for the upcoming plan year:

Plan developer/support broker name (required):

Service coordination agency (required for traditional DD Waiver and State Plan; not required for DD Waiver – Self-Directed Community Services):

Plan developer/support broker's email address:

Service coordination agency email address:

Plan developer/support broker's phone number:

I hereby authorize the Idaho Department of Health and Welfare and/or Liberty Healthcare Corporation to: (check all that apply)

- ☐ **OBTAIN AND/OR**
- ☐ **DISCLOSE**
- ☐ SCHEDULE WITH AND/OR
- ☐ RESPOND TO ASSESSMENT

My confidential information to/from the above-named service coordination agency or non-paid plan developer or independent support broker.

The following information (check all that apply) will be transmitted:

- ☐ Independent assessment results
- ☐ Functional assessment results
- ☐ Treatment plans
- ☐ Psychiatric and psychological documentation
- ☐ Physician medical documentation
- ☐ Other: (please specify)

This authorization will expire within 365 days of the date this PD Choice Form is signed unless an earlier date is provided in writing.

PARTICIPANT/LEGAL GUARDIAN (Print Name):

SIGNATURE: **Date:**

CO-LEGAL GUARDIAN (Print Name): ☐

SIGNATURE: **Date:**

THIS FORM MUST BE RETURNED TO LIBERTY HEALTHCARE