Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™

Idaho Independent Assessment Services Program
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# Respondent Choice Form

Participant Name:_____ DOB:_____

I choose the following Respondent and Alternate Respondent (should the primary Respondent become unavailable) to participate in my assessment this year:

Respondent Name: _____ Phone Number: _____

Alternate Respondent Name: _____ Phone Number: _____

OR

☐ Check if any qualified member of the agency can serve as the respondent
Agency Name: _____

My confidential information will be shared between the above-named person(s) and Liberty Healthcare for the purpose of the completion of the assessment.

This authorization is valid for use for **one** assessment and will expire within 365 days of the date this Respondent Choice Form is signed unless an earlier date is provided in writing.

Participant Name (Print): _____ DATE: _____

Participant Signature: _____

Legal Guardian Name (Print): _____ DATE: _____

Legal Guadian Signature: _____