

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: _____