Application

Idaho Home Choice

Applicant Name (Last, First, MI)			Phone - Applicant
Is The Applicant on Medicaid? ☐ Yes ☐ No			Medicaid ID #
Gender ☐ M ☐ F	Date of Birth (*mm/dd/yyyy*)	Language	County
Name of Facility			Date of Admission (*mm/dd/yyyy*)
Street Address			Phone - Facility
City	State	Zip Code	Fax - Facility

Referral Source

☐ Self ☐ MDS ☐ Hospital ☐ ICF/ID ☐ PASRR

☐ Friend ☐ Physician ☐ Nursing Facility ☐ LTC Ombudsman ☐ Other

☐ Family ☐ Community Agency (*Specify*) _____ ☐ CIL

Referred By (*name of person making referral)*	Phone – Person Referring	Referral Date (*mm/dd/yyyy)*

Does Applicant Have Income

☐ Yes ☐ No

Does Applicant Have a Mental Health Diagnosis? ☐ Yes ☐ No	Does Applicant Have a Drug/Alcohol Diagnosis? ☐ Yes ☐ No	If **Yes** *(to either)*, Is Applicant Receiving Treatment? ☐ Yes ☐ No

Other Information

Name of Legal Guardian (*If Applicable)*	Type of Guardianship ☐ Person ☐ Estate ☐ Person & Estate
Address	
City, State, and Zip Code / Phone - Guardian	
Who Else Can We Contact About The Person Being Referred?	Phone - Other
Signature of Applicant or Legal Guardian	Date (*mm/dd/yyyy)*

Send This Form To:
Idaho Home Choice Intake/Attn: Tammy Ray
Idaho Department of Health and Welfare
Division of Medicaid
3232 Elder St
Boise, Idaho 83705

Phone: (208)364-1889 or
(208)287-1172
Fax: (208)332-7283

Submit by Email