Idaho Home Choice Referral Form

Participant Information		
Name:	SS # (last 4 digits):	
DOB:	Medicaid #:	Medicare:
Is client financially eligible for waiver services? ◯ Yes ◯ No		
Street Address:		
City:	State:	Zip:
Phone #:	Alternate Phone #:	

Responsible Party (i.e., guardian)		
Name:		
Street Address:		
City:	State:	Zip:
Phone #:	Alternate Phone #:	
Email address:		
Relationship to Client:		

Institution/Facility Information (where participant currently lives)		
Facility Name:		
Facility Type: ◯ ICF/ID ◯ IMD ◯ Skilled Nursing ◯ Acute Hospital		
Street Address:		
Mailing address, if different:		
City:	State:	Zip:
Contact Person's Name:		
Phone #:	Fax #:	
Email address:		
Date admitted to institution:		

Preferred Living Arrangements		
Type	**Check one**	**Comments**
With relatives/caregiver in apartment	☐	
With relatives/caregiver in home	☐	
Alone in apartment	☐	
Alone in own home	☐	
In 4-bed or less group home (4 unrelated individuals	☐	

Please return to:

Idaho Home Choice
3232 Elder Street
Boise, ID 83705

Fax: (208)332-7283
E-Mail:IHCMFP@dhw.idaho.gov

Submit by Email

MFP Staff Use Only		
Eligibility Criteria	**Check One**	**Comments**
Meets qualified institution/facility	◯ Yes ◯ No	
In institution/facility at least 3 months	◯ Yes ◯ No	
Meets qualified residence	◯ Yes ◯ No	
Medicaid eligible	◯ Yes ◯ No	
Authorized by: Tammy Ray, Idaho Home Choice Project Manager		Date:

IDAHO DEPARTMENT OF HEALTH & WELFARE