IDAHO DEPARTMENT OF HEALTH AND WELFARE
IDAHO HOME CHOICE – REQUEST FOR QUALITY OF LIFE SURVEY

PARTICIPANT NAME:	MID or DOB:
PHONE NUMBER:	DISCHARGE DATE (Survey must be completed at least 2 weeks prior to discharge):
INSTITUTION/ADDRESS:	ROOM NUMBER:
DISCHARGE PLANNER NAME:	DISCHARGE PLANNER PHONE NUMBER:
TRANSITION MANAGER REQUESTING QOL:	TRANSITION MANAGER PHONE NUMBER:

NOTES:

Submit by Email

Please Fax completed form to 208-332-7283 ATTN: Tammy Ray/Sarah Spaulding