Print Form

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF MEDICAID
LICENSING & CERTIFICATION
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

DDA Informal Dispute Resolution Request

AGENCY NAME: _____ SURVEY EXIT: _____

TYPE OF HEARING: ☐ IN PERSON ☐ BY TELEPHONE ☐ BY MAIL

LEGAL COUNSEL WILL BE PRESENT: ☐ YES ☐ NO

AGENCY CONTACT PERSON: _____

PHONE NUMBER: _____ REQUEST DATE: _____

Please use a separate form for each rule in dispute. Give the rule number, the number(s) of the example(s) in dispute, and a brief summary of the facts that you believe refute the deficiency findings. Attach additional pages, if necessary. Please attach relevant documentation, INCLUDING A COPY OF THE DISPUTED DEFICIENCIES FROM THE SURVEY REPORT.

RULE NUMBER: _____ EXAMPLE NUMBERS: _____

FACTS THAT REFUTE THE DEFICIENCY FINDINGS:

IDR RESULTS

Deficiency is: ☐ Supported in Full ☐ Amended ☐ Deleted

Reason: _____

Chair's Signature: _____ Date: _____