



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	ICARE Supported Living, Inc.	Region(s):	4
Agency Type:	Residential Habilitation Agency	Survey Dates:	12/1/15-12/2/15
Certificate(s):	RHA-5220	Certificate(s) Granted:	<input type="checkbox"/> 6 - Month Provisional <input type="checkbox"/> 1 - Year Full <input checked="" type="checkbox"/> 3 - Year Full

Rule Reference/Text	Findings	Agency's Plan of Correction (Please refer to the Statement of Deficiencies cover letter for guidance)	Date to be Corrected (mm/dd/yyyy)
No deficiencies were cited over the course of the survey.	No deficiencies were cited during the course of the survey. The provider is not required to submit a Plan of Correction to the Department.	1. Click here to enter text. 2. Click here to enter text. 3. Click here to enter text. 4. Click here to enter text.	Click here to enter a date.

Agency Representative & Title: No signature required. <i>* By entering my name and title, I agree to implement this plan of correction as stated above.</i>	Date Submitted: 12/2/2015
Department Representative & Title: Kerrie Ann Hull, LMSW <i>* By entering my name and title, I approve of this plan of correction as it is written on the date identified.</i>	Date Approved: 12/2/2015