IDAHO DEPARTMENT OF HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	Community Partnerships of Idaho Inc	**Region(s):**	5
Agency Type:	Res Hab	**Survey Dates:**	05/16/18-05/18/16
Certificate(s):	RHA-268 Twin Falls RHA-5366 Burley	**Certificate(s) Granted:**	☐ 6 - Month Provisional ☐ 1 - Year Full ☒ 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 * By entering my name and title, I agree to implement this plan of correction as stated above.	**Date Submitted:** n/a
Department Representative & Title: Pam Loveland-Schmidt, Licensing & Certification * By entering my name and title, I approve of this plan of correction as it is written on the date identified.	**Date Approved:** 5/24/2016