IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	Scott Community Care	**Region(s):**	2
Agency Type:	Residential Habilitation Agency	**Survey Dates:**	05/24/2016
Certificate(s):	RHA-205	**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	No Deficiencies	*N/A*	*N/A*

Agency Representative & Title: *Click here to enter text.* Melan J Scott CEO * By entering my name and title, I agree to implement this plan of correction as stated above.	**Date Submitted:** *Click here to enter a date.* 5-25-16
Department Representative & Title: Click here to enter text. * By entering my name and title, I approve of this plan of correction as it is written on the date identified.	**Date Approved:** Click here to enter a date. 5/27/16