



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	A & R Case Management	Region(s):	3
Agency Type:	DDA	Survey Dates:	15 Nov 2016 – 16 Nov 2016
Certificate(s):	3A&RCASE085 DDA-5342	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.	<ol style="list-style-type: none"> 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.	Date Submitted: n/a
<i>* By entering my name and title, I agree to implement this plan of correction as stated above.</i>	
Department Representative & Title: Sandi Frelly, Medical Program Specialist	Date Approved: 11/23/2016
<i>* By entering my name and title, I approve of this plan of correction as it is written on the date identified.</i>	