



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	Childrens Therapy Place	Region(s):	5
Agency Type:	DDA	Survey Dates:	10/24/18-10/25/18
Certificate(s):	DDA-5373	Certificate(s) Granted:	<input type="checkbox"/> 6 - Month Provisional <input checked="" type="checkbox"/> 1 - Year Full <input 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. <i>n/a</i> 2. <i>Click here to enter text.</i> 3. <i>Click here to enter text.</i> 4. <i>Click here to enter text.</i>	<i>n/a</i>

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: n/a
Department Representative & Title: <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: 10/25/2018