**Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider Medicaid ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- |
| Presumptively Institutional Setting Criteria | Describe why setting meets  presumptively institutional setting criteria. | Describe remediation plan and timeline | Date Remediation Completed |
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|  |  |  |  |

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| --- | --- | --- | --- |
| Standard 1 Setting | Describe deficiency | Describe remediation plan and timeline | Date Remediation Completed |
| 1.1 |  |  |  |
| 1.2 |  |  |  |
| 1.3 |  |  |  |
| 1.4 |  |  |  |
| 1.5 |  |  |  |
| 1.6 |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Standard 2  Rooms/Privacy | Describe deficiency | Describe remediation plan and timeline | Date Remediation Completed |
| 2.1 |  |  |  |
| 2.2 |  |  |  |
| 2.3 |  |  |  |
| 2.4 |  |  |  |
| 2.5 |  |  |  |
| 2.6 |  |  |  |
| 2.7 |  |  |  |
| 2.8 |  |  |  |

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| --- | --- | --- | --- |
| Standard 3  Meals | Describe deficiency | Describe remediation plan and timeline | Date Remediation Completed |
| 3.1 |  |  |  |
| 3.2 |  |  |  |
| 3.3 |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Standard 4  Activities/Community Integration | Describe deficiency | Describe remediation plan and timeline | Date Remediation Completed |
| 4.1 |  |  |  |
| 4.2 |  |  |  |

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| Standard 5  Respect/Rights/Choice | Describe deficiency | Describe remediation plan and timeline | Date Remediation Completed |
| 5.1 |  |  |  |
| 5.2 |  |  |  |

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| --- | --- | --- | --- |
| Standard 6  Other | Describe deficiency | Describe remediation plan and timeline | Date Remediation Completed |
| 6.1 |  |  |  |
| 6.2 |  |  |  |

**Provider Representative Name:**  **Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Representative Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Submitted:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**State Agency/Managed Care Plan Representative Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Received:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**State Agency/Managed Care Plan Representative Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Response:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_