DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION SURVEY REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code

6. Medicaid Provider No.	7. Name of CEO	8. Telephone No. W1

9. State/Region code W2	10. State/County code W3	11. Dates of Survey (Begin) Month / Day / Year W4	(End) Month / Day / Year W5

12. Type of Ownership or Control (enter number in box below) W6

☐ 1. Private (non-profit) 2. Private (proprietary) 3. State 4. City/Town 5. County 6. City/County 7. Other *(specify)* _____

13. Is this ICF/MR a distinct part of a Hospital, SNF or NF? W7

☐ Yes ☐ No

14. If "Yes" to block 13, indicate either W8

A. Hospital Provider No. .....
B. SNF Provider No. .....
C. NF Provider No. .....

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in column 1 represented on the Survey team, indicate the number who also qualify as a QMRP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse		
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify) _____		
N. Total number of Surveyors onsite	W11	
O. Total number of QMRP Surveyors onsite	W12	

16. Facility Data:

A. Is this ICF/MR a residential unit within a larger organization or agency in the State that provides residential services to persons with mental retardation? *(check one)* ☐ Yes ☐ No

If *"No"*, proceed to item C. W13

B. If *"Yes,"* indicate name and address of larger organization.

Name

Address

City | State | ZIP Code

Name of CEO

Total Number of Beds	W14
Total Number of Clients *(including ICF/MR clients directly served)*	W15
C. Total Number of ICF/MR Clients	W16
D. Is this ICF/MR community-based? *(check one)* ☐ Yes ☐ No	W17
E. Total number of ICF/MR beds under this Provider No.	W18
F. Total number of discrete living units under this Provider No.	W19
G. Age range of clients served *from* ___ *to* ___	W20 / W21
H. Total number of off-campus day program sites used by ICF/MR clients	W22

17. Staffing: List the full time equivalents who function in this capacity:

A. Direct Care Personnel (483.430(d)(3))	W23
B. Registered Nurse (483.480(d)(3))	W24
C. Licensed Voc./Practical Nurse (483.480(d)(2))	W25
D. Total Personnel *(List the Full Time Equivalent for all employees)*	(W26)

18. Off-Campus Day Programs:

A. How many clients in the sample attend off-campus day programs?	W27
B. In how many off-campus day program sites was an observation done by the Surveyor?	W28