

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.	
9. State/Region code	10. State/County code	11. Dates of Survey (Begin) _____ (End) _____ Month / Day / Year		W1
12. Type of Ownership or Control (enter number in box below)		W2		
<input type="checkbox"/> 1. Private (non-profit) 3. State <input type="checkbox"/> 2. Private (proprietary) 4. City/Town		5. County	7. Other (specify) _____	
		6. City/County	W6	
13. Is this ICF/MR a distinct part of a Hospital, SNF or NF?		14. If "Yes" to block 13, indicate either		
<input type="checkbox"/> Yes <input type="checkbox"/> No		A. Hospital Provider No. B. SNF Provider No. C. NF Provider No.		
		W7		
15. Survey Team Composition		16. Facility Data:		
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.		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) <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W14		
		Total Number of Clients <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W15 (including ICF/MR clients directly served)		
		C. Total Number of ICF/MR Clients <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W16		
		D. Is this ICF/MR community-based? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No W17		
		E. Total number of ICF/MR beds under this Provider No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W18		
		F. Total number of discrete living units under this Provider No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W19		
		G. Age range of clients served from <input type="checkbox"/> <input type="checkbox"/> to <input type="checkbox"/> <input type="checkbox"/> W20 W21		
		H. Total number of off-campus day program sites used by ICF/MR clients <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W22		
17. Staffing: List the full time equivalents who function in this capacity:		18. Off-Campus Day Programs:		
A. Direct Care Personnel w23		A. How many clients in the sample attend off-campus day programs? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W27		
(483.430(d)(3)) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>		B. In how many off-campus day program sites was an observation done by the Surveyor? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W28		
B. Registered Nurse w24				
(483.480(d)(3)) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>				
C. Licensed Voc./Practical Nurse w25				
(483.480(d)(2)) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>				
D. Total Personnel (w26) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>				
(List the Full Time Equivalent for all employees)				