Form Approved
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES DEFICIENCIES REPORT (CMS-3070H)

Name of Facility:

Deficiencies		Comments
1. Data Tag Number	2. CoP/Standard Number	

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INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES DEFICIENCIES REPORT (CMS-3070H)

(Continued)

Name of Facility:

Deficiencies		Comments
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INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES DEFICIENCIES REPORT (CMS-3070H)

(Continued)

Name of Facility:

FOR INITIAL OR ANNUAL RECERTIFICATION SURVEY

I certify that I have reviewed the following requirements and conditions for (CHECK ONE): **(a) Full Survey**________, **(b) Extended Survey** ________,or **(c) Focused Fundamental Survey** ________, and unless indicated on this form, the facility was found to be in compliance with the Standards and the Conditions of Participation.

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FOR FOLLOW-UP SURVEY

For the purpose of this onsite visit, I certify that I have reviewed each Condition of Participation and related Standard(s) found not to be in compliance during the survey, which was performed on________________, and unless indicated on this form, the facility was found to be in compliance with the Standards and/or the Conditions of Participation.

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(Continued)

INSTRUCTION FOR COMPLETION THE CMS-3070H FORM

Evaluate each of the requirements identified in the ICF/IID Interpretive Guidelines, (Appendix "J" of the SOM). For each identified deficiency:

A. In the first column, identify the data tag number.

B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.

C. In column three, describe deficient facility practice and supporting findings.

D. Draw horizontal lines to separate identified tag numbers.

E. If more space is needed, photocopy the second page and add the correct page number for each additional page added.

F. Each surveyor must sign the certifying statement on the last page.

G. If there are more surveyors to sign the last page, than are lines available on which to sign, photocopy page 3, and add the additional signatures.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0062 (Expires XX/XX/202X). This is a mandatory to retain or obtain a benefit information collection. The time required to complete this information collection is estimated to average 72 hours per response, which includes the time required to perform the survey and complete the CMS-3070G, CMS-3070H & CMS-3070I forms. The time required to complete this information collection also includes the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments regarding the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

****CMS Disclosure****

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number, listed on this form, will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Donald Howard at QSOG_ICFIID@cms.hhs.gov.