IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF MEDICAID
BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036

Informal Dispute Resolution Request

Facility Name: _____ Survey Exit Date: _____

Type of Hearing requested: _____ In Person _____ Phone _____ Mail

Legal Counsel will be present: _____ Yes _____ No

Please use a separate form for each Tag in dispute. Give the Tag number, the number of the example(s) in dispute, and a brief summary of the facts that you believe refute the Tag findings. Attach additional pages, if necessary.

Tag No.: **Example Nos.:**

Facts that refute the Tag findings:

Facility Contact Person: _____ Date: _____ Phone #: _____

Please attach relevant documentation, INCLUDING A COPY OF THE DISPUTED TAGS FROM THE SURVEY REPORT.

Response – Level 2

Deficiency is: ☐ Supported in Full ☐ Amended ☐ Deleted

Reason: _____

Chairman's Signature: _____ Date: _____