

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

ON-SITE REVIEW – IMMEDIATE CORRECTION

Type of Review: <input type="checkbox"/> County Board Review <input type="checkbox"/> Licensed Facility <input type="checkbox"/> ICFMR <input type="checkbox"/> Waiver <input type="checkbox"/> Unlicensed Waiver <input type="checkbox"/> I.O. <input type="checkbox"/> Level One <input type="checkbox"/> TDD <input type="checkbox"/> SELF <input type="checkbox"/> HCBS Day Services	Date of Review: County/Provider Name:
Type of Provider: <input type="checkbox"/> Agency Provider <input type="checkbox"/> Individual Provider <input type="checkbox"/> County Board of DD	Facility/Provider #:
Type of Review: <input type="checkbox"/> Desk <input type="checkbox"/> Onsite	Contact Information:

Condition(s) which exist that present an immediate risk to individual’s health, safety or welfare.

Citation: _____

Describe Condition(s): _____

Action needed: _____ Immediately; _____ Within 24 hours

Provider Action Taken: _____

Use additional pages if necessary

Review Specialist Signature

Provider Signature/Title