QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL (QIDP) INFORMATION

State Form 48318 (R3 / 6-17)
Indiana State Department of Health – Division of Long Term Care

To: All ICF / IID Providers

From: ICF / IID Program Directors
Division of Long Term Care

Re: Regulation 483.430(a)

Please provide the following information for each facility / home and give this form to the surveyor at the time of your exit conference.

Name of provider / agency
Address of home / facility *(number and street, city, state, and ZIP code)*

NAME OF QIDP	DEGREE OR LICENSE	EXPERIENCE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Signature of surveyor	Date *(month, day, year)*