

Provider Name: _____

Date Completed: _____ By: _____

Documentation Maintained and Services Provided at each NHTD Provider Address
 (This information is used to establish the scope of survey activities.)

Provider Address(es)	Quality Mngmt Info. (i.e. policies/procedures)	Incident Reporting	Employee Files (i.e. quals; training, etc.)	Documentation Maintained/Services Provided from Each Address																		
				SC	Assis. Tech.	CIC	CTS	Meals	Emods	HCSS	Home Visits	ILST	Moving Assist.	Nutri. Counsel	Peer Ment.	PBIS	Resp. Ther.	Respite	SDP	Wellness Coun.		

**Enter the physical address for each office/address that services will be provided out of AND/OR documentation is maintained.

**Enter a check mark under each column to indicate the records retained and the services provided at each location.