



Office for People With Developmental Disabilities

KATHY HOCHUL

Governor

KERRI E. NEIFELD

Commissioner

WILLOW BAER

Executive Deputy
Commissioner

Provider Report of Deficiency Dispute

Directions: Form must be filled out completely and signed by the Executive Director and emailed by the Executive Director to quality@opwdd.ny.gov. This is the only acceptable method to submit this form. The information must be sent within 5 working days of receipt of the survey findings on the Statement of Deficiencies (SOD), and 3 working days of receipt of a 45-day SOD with letter. Include copies of Exit Conference Form and the Statement of Deficiency, as well as the 45-day letter (if applicable). Please note that only SOD Level deficiencies can be disputed in this process. See Provider Instructions for additional process requirements.

Agency Legal Name:				
Date of Review/Survey as appears on SOD:				
Type of Review/Protocol Implemented (Site/PCR/Agency):				
<p>If Site Review:</p> <p style="padding-left: 20px;">Program Type:</p> <p style="padding-left: 40px;">Operating Certificate #:</p> <p style="padding-left: 40px;">Site Address:</p> <p>If Person Centered Review:</p> <p style="padding-left: 20px;">Individual Name:</p> <p style="padding-left: 20px;">TABS# (if available):</p> <p style="padding-left: 20px;">Site/Service with Disputed Deficiency (please indicate all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Care Management <input type="checkbox"/></td> <td style="width: 50%;">Certified Site-Based Services <input type="checkbox"/></td> </tr> <tr> <td>Community Based Habilitation Services <input type="checkbox"/></td> <td>Other Waiver Services <input type="checkbox"/></td> </tr> </table> <p style="padding-left: 20px;">Operating Certificate #:</p> <p style="padding-left: 20px;">If Certified Site, Address of Program:</p>	Care Management <input type="checkbox"/>	Certified Site-Based Services <input type="checkbox"/>	Community Based Habilitation Services <input type="checkbox"/>	Other Waiver Services <input type="checkbox"/>
Care Management <input type="checkbox"/>	Certified Site-Based Services <input type="checkbox"/>			
Community Based Habilitation Services <input type="checkbox"/>	Other Waiver Services <input type="checkbox"/>			
Date SOD was received electronically by the agency: _____				
<p>If concerns were discussed with BPC Survey Team/Management prior to deficiency dispute submission, please provide the following information-</p> <p>Date(s) & Name(s) of BPC members:</p> <p>_____</p> <p>_____</p>				

General Topic Area(s) of Disputed Deficiency/Deficiencies: (e.g., Health Care, Behavior Supports, Service Planning, etc.)

Standard(s) of Disputed Deficiency(ies):

Agency Justification for Dispute: Brief narrative describing the evidence supporting the agency's conclusion that the deficiency is not warranted or is incorrect. The conclusion must be based on the documentary evidence that was available to surveyors during the completion of the survey/review. Documentation to support the agency's rationale for the dispute must be submitted with the deficiency dispute form. Supporting documentation must have been in existence at the time of the survey (i.e., a Plan of Protective Oversight, Life Plan, Behavior Support Plan, staff training records, staffing schedule, Fire Evacuation Plan, etc.).

_____	_____	_____
Executive Director Name	Executive Director Telephone	Executive Director Email Address
_____		_____
Executive Director Signature		Date