TEXAS Department of Aging and Disability Services

Form 3026
March 2015-E

Random Sample Review of Nursing On-call and/or Deceased Individual Required Submission of Documentation

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICFs/IID)

Note: ICFs/IID must submit all requested information to DADS **within five business days** after receipt of this form. Additional documents may be requested after the initial review by DADS.

To: Waiver Survey and Certification
Mailing Address: 5451 N. IH-35, Suite D
Austin, TX 78723

Attn: Administrative Assistant
Fax No.: 512-919-7231

Provider Name	Contract No.	Facility ID No.	CARE Component Code

Date Submitted to DADS	Submitted By	Area Code and Telephone No.	Area Code and Fax No.

Contact	Contact Area Code and Telephone No.

Name of Individual	CARE ID No.	Date of DADS Request

ICFs/IID must **fax** or **mail** copies of the following documents for the individual noted above to DADS.

The most recent:

	Sent	If no, reason not sent:
• behavior management program;	☐ Yes ☐ No	
• comprehensive nursing assessment;	☐ Yes ☐ No	
• nursing service plan; and	☐ Yes ☐ No	
• quarterly nursing or annual physician physical exam (whichever is the most current).	☐ Yes ☐ No	

The most current three months dated _____ to _____ :

	Sent	If no, reason not sent:
• behavioral incident reports;	☐ Yes ☐ No	
• direct care staff progress notes;	☐ Yes ☐ No	
• incident reports;	☐ Yes ☐ No	
• laboratory/X-ray records;	☐ Yes ☐ No	
• medical consults;	☐ Yes ☐ No	
• medication administration records;	☐ Yes ☐ No	
• nurse progress notes;	☐ Yes ☐ No	
• physician orders; and	☐ Yes ☐ No	
• physician progress notes.	☐ Yes ☐ No	

	Sent	If no, reason not sent:
List of registered nurses' and licensed vocational nurses' names and titles along with corresponding signatures of each nurse.	☐ Yes ☐ No	

FOR DADS USE ONLY: ☐ **Random Sample Documentation** ☐ **Deceased Individual Documentation**