|  |  |  |  |
| --- | --- | --- | --- |
| **Contractor Name** |  | **Systemic Case, if applicable** |  |
| **Name of person who conducted onsite** |  | **Contact Number** |  |
| **Name of person submitting form** |  | **Contact Number** |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Health and Safety Onsite Review** | **Facility Name** | **Facility Address** | **AHCCCS Provider ID** | **Member Name** | **AHCCCS ID Number** | **Description of Concerns Identified During Health and Safety Review including the individual IAD/IRF/QOC case id when applicable.** | **Action Taken**  ***(e.g. Corrective Action Plan [CAP], Monitoring and Frequency, Move Members, Bed Hold)*** | **Date of Member Move** |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |