**INSTRUCTIONS:**

Title 42 CFR 488.331 requires that the Centers for Medicare and Medicaid Services (CMS) and the States, as appropriate, offer skilled nursing facilities, nursing facilities, and dually participating facilities an informal opportunity to dispute cited deficiencies upon the facility’s receipt of the official Statement of Deficiencies (Form CMS-2567). To initiate this process in New York State, the Informal Dispute Resolution (IDR) Form and all supporting documentation must be submitted with your Plan of Correction (POC) within ten (10) calendar days of receipt of Form CMS-2567. **Complete fields A through I electronically and submit this form for EACH cited deficiency you wish to dispute.** The fields will expand as you type. When completed, submit the form in Word format and the supporting documentation labeled appropriately to idr@health.ny.gov as instructed below:

**Administrative IDR (Scope/Severity B through F excluding Substandard Quality of Care)**

* The IDR Form, left in ***Word format*** and,
* All relevant supporting documentation labeled appropriately; form CMS 2567; and the Plan of Correction (POC) to idr@health.ny.gov.

 **Panel IDR (Substandard Quality of Care and Scope/Severity G and above)**

* The IDR Form, left in ***Word format*** and,
* All relevant supporting documentation labeled appropriately; form CMS 2567; and the Plan of Correction (POC) to idr@health.ny.gov

**Panel IIDR (Scope/Severity G and above)**

* The IDR Form, left in ***Word format*** and,
* All relevant supporting documentation labeled appropriately; form CMS 2567; and the Plan of Correction (POC) to idr@health.ny.gov.

|  |  |  |  |
| --- | --- | --- | --- |
| **Administrative IDR:** [ ]  |  | **Panel IDR:** |[ ]  **Panel IIDR:** |[ ]
|  |
| 1. **FACILITY NAME:**
 | Click or tap here to enter text. |
|  |
| 1. **SURVEY EXIT DATE:**
 | Click or tap to enter a date... |
|  |
| 1. **DATE ELECTRONIC IIDR/IDR FORM SUBMITTED:**
 | Click or tap to enter a date. |
|  |
| 1. **DATE IIDR/IDR SUPPORTING DOCUMENTATION SUBMITTED:**
 | Click or tap to enter a date. |
|  |
| 1. **INDICATE THE APPROPRIATE REGIONAL OFFICE:**
 |
|  |
|[ ]  **Western – Buffalo** |[ ]  **Western – Rochester** |
|  |
|[ ]  **Capital District** |[ ]  **Central New York** |
|  |
|[ ]  **Metropolitan – New Rochelle** |[ ]  **Metropolitan – New York City** |
|  |
|[ ]  **Metropolitan – Long Island** |  |  |
|  |
| 1. **DISPUTED DEFICIENCY:**
 | Enter Deficiency… | 1. **SCOPE & SEVERITY:**
 | Enter Scope/Severity… |
|  |
| 1. **LIST DOCUMENTS YOU ARE ENCLOSING THAT ARE RELEVANT AND SUPPORT YOUR CLAIM: (label the attachments accordingly.**
 |
|  |
| List Relevant Documents here… |
|  |
| 1. **FACILITY DISPUTE:**
 |
|  |
| Type Facility Dispute here… |

|  |
| --- |
| **FOR DEPARTMENT OF HEALTH USE ONLY:** |
|  |
| 1. **REGIONAL OFFICE RESPONSE AND RECOMMENDATION:**
 |
|  |
| Click or tap here to enter text here... |
|  |
| 1. **PANEL RECOMMENDATION (only for SQC and Scope/Severity G and above):**
 |
|  |
| Click or tap here to enter text here... |