COUNTY CERTIFICATION OF COMPLIANCE
WITH DRUG MEDI-CAL
POST SERVICE POST PAYMENT
CORRECTIVE ACTION PLAN

I hereby certify that _____, DMC #_____, has
(Provider Name)
fully implemented all corrective actions documented and submitted to the Department of

Health Care Services on _____.
(Date of Provider CAP)

_____ _____
Print Name Title

_____ _____
Signature Date

_____ _____
Phone E-mail

_____ _____
Agency County

Regulation:
State County Contract SFY 14/15
Exhibit A, Attachment I, Part V, Section 4, B (1)(d):

> *Contractor must monitor and certify compliance and/or completion by Providers with CAP requirements (detailed in Section 4, Paragraph (A)(2)(c))as required by any PSPP review. Contractor shall certify to DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Contractor and/or the Provider. Submission of form by Contractor must be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.*

Please submit form to: SudCountyReports@dhcs.ca.gov