



**COUNTY ATTESTATION TO COMPLIANCE
WITH DRUG MEDI-CAL
POST SERVICE POST PAYMENT
CORRECTIVE ACTION PLAN**

I hereby attest 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