

**COMPLETION INSTRUCTIONS FOR COUNTY ATTESTATION TO COMPLIANCE WITH DRUG MEDI-CAL POST SERVICE POST PAYMENT CORRECTIVE ACTION PLAN DHCS 8049**

**GENERAL**

The County Attestation to Compliance with Drug Medi-Cal Post Service Post Payment Corrective Action Plan Form is used to attest to a providers' full implementation of a Corrective Action Plan (CAP) generated as a result of a DHCS Post Service Post Payment review. The form must be completed and submitted to DHCS by the County Substance Use Disorder Program Administrator or County designated authority after on-site verification of CAP implementation.

**HEADING INSTRUCTIONS**

- PROVIDER NAME: enter the name of provider for which the Corrective Action Plan was submitted.
- DMC #: enter Drug Medi-Cal provider number assigned by DHCS.
- DATE OF PROVIDER CAP: enter the date the approved CAP was submitted.

**SIGNATURE BLOCK INSTRUCTIONS**

- PRINT NAME: print the name of individual authorized to submit form.
- TITLE: print title of individual authorized to submit form.
- SIGNATURE: authorized submitter must sign.
- DATE: enter date form is submitted to DHCS.
- PHONE: enter phone number of authorized submitter.
- E-MAIL: enter e-mail address of authorized submitter.
- AGENCY: enter name of Agency submitting form.
- COUNTY: enter name of county from which form is submitted.

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