STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF HEALTH CARE SERVICES

COMPLETION INSTRUCTIONS FOR COUNTY CERTIFICATION OF COMPLIANCE WITH DRUG MEDI-CAL POSTSERVICE PREPAYMENT/ POSTSERVICE POSTPAYMENT CORRECTIVE ACTION PLAN DHCS 8049

GENERAL

The County Certification of Compliance with Drug Medi-Cal PostService Prepayment/PostService Postpayment Corrective Action Plan Form is used to certify a providers' implementation of a DHCS accepted Corrective Action Plan (CAP) generated as a result of a DHCS Postservice Prepayment/Postservice Postpayment 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 CAP was accepted.

SIGNATURE BLOCK INSTRUCTIONS

- COUNTY AGENCY NAME: Enter name of the Agency submitting form.
- NAME OF COUNTY: Enter name of the county submitting form.
- BUSINESS PHONE NUMBER: Enter phone number of authorized submitter.
- BUSINESS E-MAIL: Enter e-mail address of authorized submitter.
- PRINT NAME, FIRST AND LAST: Print the name of individual authorized to submit form.
- WORKING TITLE: Print title of individual authorized to submit form.
- SIGNATURE: An authorized submitter must sign.
- DATE: Enter date form is submitted to DHCS.