

**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

- PRINT NAME: Print the name of individual authorized to submit form.
- TITLE: Print title of individual authorized to submit form.
- SIGNATURE: An 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 the Agency submitting form.
- COUNTY: Enter name of the county submitting form.