

Date

Provider Name

Address

Address

RE: Name of Provider Agency/Individual
ODMRDD Provider Number:
County:
Waiver:
Certified Services:

Dear (Provider):

The Ohio Department of Mental Retardation and Developmental and/or the local County Board of MR/DD are required to conduct provider compliance reviews at least every five years. This is in accordance with Rule 5123:2-9-08 "Compliance reviews of certified HCBS waiver providers".

This letter will serve as notification that you (or your agency) will have a review within the next 10 to 21 calendar days.

This review will be conducted as a "Desk Review". In order to prepare for this survey, please reference the enclosed "**Required Documents List**" for information that will need to be submitted to the attention of **(type in name of reviewer)**.

All requested documentation must be submitted to this office via fax or mail. The fax number and mailing address are listed below. **All documentation must be received by the close of business on (type in month/day/year)**. This date will indicate the "Date of Review" for tracking purposes. Any documentation that is not received in this office by the close of business on that date **will not be accepted** as part of information submitted for the review.

A report will be issued within 21 calendar days from the date of the review. Any documentation received after the close of business on the date of the review may need to be resubmitted as part of the documentation that is submitted with the Plan of Compliance to substantiate the correction of a finding listed on the report, should one be required.

Please direct the required documentation to the contact listed below. Photocopies of the documentation are acceptable as the information will not be returned to you.

Please note that failure to cooperate with this Provider Compliance review process may result in a recommendation by the Department for further action related to your certification.

If you have any questions about the review or the required documents, please feel free to contact:

Name

Survey Source: (CB / COG / ODMRDD)

Address

Address

Phone number

Fax number

E-mail address

Sincerely,

Name

Title