INSERT HEADER HERE

Date

Provider Name
Address

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

Dear (Provider):

The Ohio Department of Mental Retardation and Developmental Disabilities (Department) or the local County Board of Mental Retardation and Developmental Disabilities, if requested by the Department, is 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. OR-This letter will serve as notification that you (or your agency) and this office have confirmed that a provider compliance review will be conducted on ___________________.

In order to prepare for this survey, please reference the enclosed **"Required Documents List"** for information that will need to be available on the day of the review. The review will occur in your management office or at a mutually agreed upon location.

A representative of the Provider Compliance review team will contact you to confirm the date of review.

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:

Reviewer's Name
Dept, County Board or Cog
Address
Phone and Email Address

Sincerely,

SIGNATURE and TITLE
AFFILIATION