

**PROVIDER COMPLIANCE INITIAL REPORT
“PROVIDER ACKNOWLEDGEMENT” FORM**

(TO BE COMPLETED & RETURNED TO CONTACT NOTED BELOW)

Re: Provider Name:
Provider County:
Provider Contact Name and Title:
Provider Phone Number: Area Code- ()
Provider Email Address: (If available)
Date/s of Review:
Survey Team- County Board:
HCBS Waiver(s) Reviewed (Billed in past 12 months): **IO LEVEL 1**
Certified Service(s) Reviewed (Billed in past 12 months):

Please return this completed “**Acknowledgement**” form (PC044), along with your completed Plan of Compliance (see Items # 1 & 2 below) within 14 calendar days of the date on the cover letter accompanying the “Provider Compliance Review-Report of Initial Findings”.

Check only ONE box below that applies:

- 1 PROVIDER CONCURS WITH THE FINDINGS** outlined in the initial Provider Compliance Review Report. When responding, include your Plan of Compliance responses to each finding on the Provider Compliance Report form (PC045). Remember to include all required elements in your POC responses as outlined in the “How to Complete the Plan of Compliance” forms (PC057CB and PC058 Dept). Include documentation to support your plan of compliance.

- 2 PROVIDER DOES NOT CONCUR WITH THE FINDINGS** outlined in the initial compliance report. When responding, include your Plan of Compliance responses to each finding on the Provider Compliance Report form (PC045). Remember to include all required elements in your POC responses as outlined in the “How to Complete the Plan of Compliance” forms (PC057CB enclosed). Include documentation to support your objections to the specific findings that you are informally disputing as well as for findings that were not disputed. An informal meeting/discussion on the written objections will be planned after receipt of the written response.

Return completed form to:

INSERT Contact Name & Address

Signature: SOLE PROPRIETOR, CEO OR PROVIDER DESIGNEE SIGNATURE / TITLE	DATE SIGNED