

INSERT LETTERHEAD HERE

Date

Provider Name
Address
City/State/Zip

RE: Provider Compliance Review
County:
ODMRDD Provider Number:
Plan of Compliance Received: (Date)

Dear (Provider),

Thank you for submitting your Plan of Compliance for the Provider Compliance Review completed on **(DATE)**.

The Plan of Compliance, and the supporting documentation, satisfactorily addresses the findings identified in the review. The _____ County Board of MRDD may contact you to verify the implementation of your POC at a later date. No further follow up activities are required at this time.

Thank you for your cooperation during this review process. If you have any questions, please contact this office at () _____.

Sincerely,

***SIGNATURE and TITLE
AFFILIATION***