

Date

Provider Name
Address

RE: Provider Compliance Review
ODMRDD Provider Number:
Plan of Compliance-Developed by (Dept/CB): _____
Date of Review:
County:

Dear (Provider),

We are in receipt of your response to the Plan of Compliance that was developed by the (Dept / CB) for your use in addressing the findings that were identified during the provider compliance review of **(DATE)**. This Plan of Compliance was mailed to you on **(DATE)**.

The documentation that you have submitted showing evidence of your compliance to the items in the **(DEPT / CB)** developed Plan of Compliance has been accepted.

No further follow up activities are required at this time.

If you have any questions, please contact this office at () _____.

Sincerely,

SIGNATURE