ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Office of Licensing, Certification and Regulation (OLCR)
Home and Community Based Services (HCBS) Certification

CORRECTIVE ACTION PLAN (AGENCY)

Audit Date/Time: ____________________

Agency's Name: ______________________________ FEIN: _________________ AHCCCS NO.: ____________________

This Corrective Action Plan must be completed and returned within 30 days of this audit with an updated Staff Matrix.

Describe your current system or what will be in place by __________________ to avoid HCBS non-compliance at the next audit. May attach alternate form.

Action Taken to Correct the Non-Compliance(s)

Action Taken to Prevent the Recurrence of the Non-Compliance(s)

Service Provider's Name *(Print or type)*: ____

Service Provider's Signature: ____ Date: __________________

DES/LCR
Site Code 077F
HCBS Auditor
P.O. Box 6123
Phoenix, Arizona 85005-6123

Routing: Original –Central Office; **Copy** –Service Provider

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1