**FRESNO COUNTY MENTAL HEALTH PLAN**

STATEMENT OF DEFICIENCIES AND CORRECTIVE ACTION PLAN

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| --- | --- |
| Name of Provider | Street Address, City, State, Zip Code |
|  |  |
| Date of review: |  | Period of Review From: |  | To: |  |
| Item # | Category | Summary Statement of Deficiencies | Provider’s Plan of Correction | Completion Date |
|  |  |   |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Provider’s Signature\* | Title | Date |
| **\*** |  |  |
| If deficiencies are cited, an approved corrective action plan is required to continue program participation. |