**FRESNO COUNTY MENTAL HEALTH PLAN**

STATEMENT OF DEFICIENCIES AND CORRECTIVE ACTION PLAN

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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. | | | | | | | | | |