

MEDICAID WAIVER UNIVERSAL CORRECTIVE ACTION PLAN

Completion of this form is mandatory. Centers for Medicare and Medicaid Services requires completion as a condition of approval of Sec. 1915 c waiver program. Failure to complete the form will result in the loss of Federal matching funds for Waiver Services.

PART I – AGENCY AND REPORT INFORMATION

1. Waiver Type

BIW CIP 1A CIP 1B CLTS COR IRIS

2. Name – Waiver Agency

3. HSRS Number – Waiver Agency

4. Name – State Contact

5. CIS Number

6. Waiver Agency Contact Information

Name – Primary Contact

Telephone Number

Address (Street, City, State, Zip Code)

E-mail Address

7. Report Number

Two Digit Year _____

Sequential for Agency _____

8. Date Report Submitted

PART II – INDIVIDUAL CORRECTIVE ACTION

1. Adverse Finding / Deficiency Number

Two Digit Year _____ Sequential for Agency _____

2. Adverse Finding / Deficiency Description

3. Year Deficiency Occurred

4. How / Where Adverse Finding Discovered

- | | |
|---|---|
| <input type="checkbox"/> Initial Plan / Application Review* | <input type="checkbox"/> Record Review* |
| <input type="checkbox"/> Person-centered / Field Review – Random* | <input type="checkbox"/> Person-centered / Field Review – Targeted* |
| <input type="checkbox"/> Waiver Agency Audit* | <input type="checkbox"/> Provider Agency Audit |
| <input type="checkbox"/> Incident Report / Intervention | <input type="checkbox"/> Complaint / Grievance / Hearing – Consumer |
| <input type="checkbox"/> Restrictive Measure Application | <input type="checkbox"/> Report by Licensing Agency |
| <input type="checkbox"/> Report from Public / Provider Staff | <input type="checkbox"/> Error: Policy Clarification / Change |
| <input type="checkbox"/> Other—Specify: _____ | |

**Numbered items are used in the protocols; enter the number of the item in field 5*

5. Item Number in Discovery Protocol

6. Policy / Authority Reference

7. CMS / Waiver Assurance

- | | | |
|--|---|--|
| <input type="checkbox"/> Level of Care / Eligibility | <input type="checkbox"/> Service Plan Adequacy | <input type="checkbox"/> Provider Qualifications |
| <input type="checkbox"/> Health, Safety and Welfare | <input type="checkbox"/> State Administrative Authority | <input type="checkbox"/> Fiscal Accountability |
| <input type="checkbox"/> None—State-level Issue | | |

8. Initial Proposal for Corrective Action

9. Corrective Action Description

10. Imposed or Recorded

- Imposed
 Recorded

11. Date – Communicated to Waiver Agency

12. Date by Which Remediation to be Completed

13. Name – Waiver Agency Contact (if different than contact listed in Part I)

NOTE: Items 14 – 17 are not required for Initial Submission

14. Date – Corrective Action Plan Actually Completed	15. State Approval <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Approved
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16. Disallowance <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount	Date	CY Applied to
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17. Name / Title – State Staff Approving or Receiving

18. Notes # 1 – Initial Report

19. Notes # 2 – Final Report