BHSF Form AC-8a
Revised 2004

MEDICAID PROGRAM
MONITORING CORRECTIVE ACTION RESULTS

Initial Inspection/Monitoring Date _____
30-Day Corrective Action Date _____
60-Day Corrective Action Date _____

APPLICATION CENTER NAME_____ AC ID# _____

AC STREET ADDRESS _____ P.O. BOX _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

AC PHONE NUMBER (_____) _____ AC FAX NUMBER (_____) _____

AC E-mail Address_____

Corrective Action Measure(s) Completed? ❑ Yes ❑ No

Corrective Action Measure(s) Not Completed? ❑ Yes ❑ No

EXPLANATION/COMMENTS: *(Attach an additional sheet for comments if necessary.)*

RECOMMENDATIONS: *(Attach an additional sheet for recommendations if necessary.)*

Signature of Regional Administrator Date