

**Office of Provider Standards & Review**

John R. Kasich, Governor  
John L. Martin, Director

2013

**Provider Name**  
**Provider Address**  
**City, Ohio Zip**

**RE: Compliance Review**  
**Facility/Provider #**  
**County:**

Dear **Provider Name**,

This letter will serve as confirmation that the Department of Developmental Disabilities will conduct a compliance review on **Enter Date of Review** at **Enter Start Time of Review**.

Enclosed you will find the following documents:

01. Individual Sample Key - names of individuals to be included in the review
02. Staff Sample Key - names of staff to be included in the review (**AGENCY ONLY**)
03. Required Documents List - documents to be made available during the review.
04. Provider Questionnaire – complete a form for each individual in the sample/have forms available at the time of the review. (**ICFDD Please Disregard**)
05. Review Tool / Self-Review Tool – The Office of Provider Standards and Review staff will complete this tool during the onsite review. It is being provided to you for self-review and preparation.

If you have questions contact me at.

Sincerely,

, Review Specialist  
Office of Provider Standards and Review  
Ohio Department of Developmental Disabilities

Cc: ,Superintendent