

# OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

## *Plan of Correction Verification Form*

<b>Type of Review:</b> <input type="checkbox"/> County Board Review <input type="checkbox"/> Licensed Facility <input type="checkbox"/> ICFMR <input type="checkbox"/> Waiver <input type="checkbox"/> Unlicensed Waiver <input type="checkbox"/> I.O. <input type="checkbox"/> Level One <input type="checkbox"/> TDD <input type="checkbox"/> SELF <input type="checkbox"/> HCBS Day Services	<b>Date of Initial Review:</b>  <b>County/Provider Name:</b>
<b>Type of Provider:</b> <input type="checkbox"/> Agency Provider <input type="checkbox"/> Individual Provider <input type="checkbox"/> County Board of DD	<b>Facility/Provider #:</b>
<b>Type of Verification:</b> <input type="checkbox"/> On- Site Verification <input type="checkbox"/> Desk Verification	<b>Date(s) of Verification:</b>

**Please Check Applicable Boxes**

- Plan has been verified and all citations have been corrected.
- All cited areas, with the exception of extended timelines (interior/exterior renovation), have been corrected.

Extended timelines will be verified on or about: \_\_\_\_\_

- Outstanding citations remain:

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**Return Verification Required:**       YES       NO

Date of Return Verification: \_\_\_\_\_

- Additional citations have been issued and will be mailed under separate cover.

\_\_\_\_\_  
Review Specialist Signature

\_\_\_\_\_  
Provider Signature/Title