Audit CAP Form (Program Review)

Preliminary Results to Delegate Name

Issue Date: MM/DD/YYYY

Delegate/Auditee: (*Entity Name*)
Audited Function: (*Area reviewed)*
Review Period: (*Date*)

SCOPE CATEGORY:			
CITATION(s):			
DEFICIENCY NUMBER:	**DELEGATE/AUDITEE RESPONSES** **Response and Action(s) taken.** **Include dates completed/anticipated.**	**PHC Auditor (Approved/Not Approved)** Include final comments or request(s) and the date of each new entry.	**Result** **OPEN /** **Closed**
FINDINGS: **MM/DD/YYYY:** **___ of ___ cases (____% preliminary score)** **Documents reviewed:** Click here to enter text.	**Written response MM/DD/YYYY**: Click here to enter text. **Supplemental Document(s) Submitted:** Click here to enter text.	**MM/DD/YYYY: Approved/Not Approved –** ***<Paste chosen standard result language from the CAP Form Guide - Final Results Key>***	
PRELIMINARY CAP(s): ***Submit the following to demonstrate compliance with the above cited requirement:*** ▪			

Responsible Party

Delegated Entity: Click here to enter text.

Name: Click here to enter text.
Title: Click here to enter text.

Electronic Signature:

Partnership Health Plan of California

Review and Approved by:

Name: Click here to enter text.
Title: Click here to enter text.

Electronic Signature: