### DEPARTMENT OF HEALTH & HUMAN SERVICES

**Division of Audit**

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| AUDIT RESOLUTION -- CORRECTIVE ACTION PLAN |
| **Community Agency Name:** |  |
| **Address:** |  |
| **Program Name(s):** |  |
| **Fiscal Year Ended Date:** |  |
| **DHHS Division of Audit/IPA Finding or Reference #:**  |
| Restate Finding as it Appears in the Examination/Audit Report: |
|  |
| **Corrective Action:** Must include names(s), job title(s) and telephone numbers(s) of the individual(s) responsible for carrying out the corrective action plan, the necessary steps leading to resolution along with an implementation timeline and an anticipated completion date. |
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| **DHHS Division of Audit/IPA Finding or Reference #:** |
| Restate Finding as it Appears in the Examination/Audit Report: |
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| **Corrective Action:**  |
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| **Corrective Action:**  |
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| Name & Title of Agency Representative (typed): | Signature of Agency Representative & Date: |
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| Submit to: | Social Services UnitDepartment of Health & Human ServicesFinancial Services - AuditState House Station #11Augusta, Maine 04333 | Tel.FaxTTD | (207) 287-2403(207) 287-26011-800-606-0215 |