DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-17
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF BURDEN REDUCTION AND HEALTH INFORMATICS

**Corrective Action Follow up Letter**

Date of Notice: FULL DATE

CONTACT NAME
JOB TITLE
CE NAME
ADDRESS 1
ADDRESS 2
CITY, ST ZIP

Re: Corrective Action Number **XXXXX**

Dear TITLE LAST NAME:

In a Corrective Action notice dated (month, day, year), we informed you that the Department of Health and Human Services (HHS), National Standards Group (NSG) within the Centers for Medicare & Medicaid Services' (CMS), initiated a corrective action based on HIPAA violations discovered during the **<Covered Entity Name>** 2017 assessment. In that notice, we requested that you provide a Corrective Action Plan (CAP) that addresses the violations by (month, day, year). To date, this office has not received a CAP, or a completed CAP, from **<Covered Entity Name>**.

Please submit a completed CAP by (month, day, year) to the HIPAA mailbox at hipaacomplaint@cms.hhs.gov, or submit it to the National Standards Group at:

Centers for Medicare & Medicaid Services
HIPAA Enforcement
Attn: National Standards Group
P.O. Box 8030
Baltimore, MD 21244-8030

Failure to provide a completed CAP will be considered willful neglect and may result in the imposition of civil money penalties.

If you have any questions about this letter, please contact (contact name) at contact_name@cms.hhs.gov, or 555-555-5555. When contacting this office, please include the corrective action number located at the top of this letter.

Sincerely,
Michael Cimmino, Director
National Standards Group
Office of Burden Reduction and Health Informatics

cc:
Contact Name

In accordance with the Paperwork Reduction Act (1995), no persons are required to respond to a collection of information, unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is **0938-XXXX (Expires XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **[10 hours]** per response (4 forms x 60 minutes/form), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

Centers for Medicare & Medicaid Services
Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact: Kevin Stewart at kevin.stewart@cms.hhs.gov .

**CAP Template**

| | | |
|---|---|---|
| **Assessed Entity Name:** | **Submitted by (Name):** | **Phone Number:** |
| **Corrective Action Number:** | **Submission Date:** | **Email Address:** |

| **Violation Description from Notice** | **Root Cause of Violation (Optional)** | **Notes/Comments** |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **5.** | | |
| **6.** | | |

| Major Milestones | Planned Start Date | Planned Completion Date | Responsible Party or Position |
|---|---|---|---|
| *Example: code updates* | *01/01/24* | *01/10/24* | *Developers* |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

***For NSG Official Use Only***

Assessor 1 Signature: _____

*Assessor 1*

Approval Date: _____

*Month Day Year*