

**County of San Bernardino  
Department of Behavioral Health  
Homeless Shelter Corrective Action Plan**

DISTRIBUTION:  
Pink: Original  
White: Case File and Provider

Date:	Name of Shelter:
DBH Representative:	Address:
	Phone Number:

The following Corrective Action Plan has been discussed with and agreed to by the provider/house manager and it is to be completed within the period specified below.

Review Area	Description of Deficiency	Action to be Taken by Provider:	Correction to be Completed by:

<b>I have received and reviewed a copy of this Corrective Action Plan with the DBH Representative:</b>	Provider/House Manager Signature:	Date:
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<b>SAN BERNARDINO COUNTY-DEPARTMENT OF BEHAVIORAL HEALTH ONLY</b>	
<b>The above deficiencies have been corrected in accordance with this Corrective Action Plan and were verified.</b>	
Name of DBH Representative (Please Print):	Signature of DBH Representative:
DATE:	DBH PMII SIGNATURE: