CORRECTIVE ACTION PLAN

Participant Name:				
Participant ID Number:				
Representative (if applicable):				
Phone Numbers	**Participant:**		**Representative**:	

Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s)).

1.

Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)

Monthly Updates (to be completed at time of monthly contact with participant/representative). Consultant to indicate if each action step has been completed as described above. If action step was not completed as indicated, consultant to explain reason for noncompliance and action taken to rectify situation. Date each entry, initial and submit to Area Liaison.

Date and Consultant Name	Update

Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s)).

2.

Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)

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Date and Consultant Name	Update

CORRECTIVE ACTION PLAN

Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s)).	
3.	
Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)	
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Date and Consultant Name	Update

Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s)).	
4.	
Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)	
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Date and Consultant Name	**Update**

CORRECTIVE ACTION PLAN

Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s)).
5.
Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)
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Date and Consultant Name	**Update**

CAP will be monitored until all corrections to the identified problems have been successfully met.

I acknowledge that I will not exceed the spending limits set forth in this Corrective Action Plan. (Initial)_____
Failure to comply with the stated action steps to achieve correction of the identified problem(s) within established timeframes may result in the participant's disenrollment from the CDC+ program and return to the DD/HCBS waiver.

Implementation Date::		Review Date:		Date Problem Resolved	

Participant/Representative Signature:	_____	Date:	
Consultant Signature:	_____	Date:	
Area APD Liaison Signature:	_____	Date:	
Central APD Office Signature:	_____	Date:	