**Division of Family & Community Services**

**Office of Workforce Development**

**Corrective Action Plan/Exit Tool**

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| --- | --- | --- | --- |
| **Responsible Bureau:** | **Employment & Training** | | |
| **Reviewer Name(s):** | **Date of Review:** | | **Review Type:** |
| **Provider Name:** | **Provider Contact Information:** | | **Program Name:** |
| **Finding Statement(s):** | | | |
| **Factors contributing to the Finding:** | | | |
| **Recommendation(s):** | | | |
| **Monitoring Report Submitted by (if applicable):** | | **Date:** | |
| **Program Manager Name/Signature:** | | **Date:** | |
| **Summary of Visit:** | | | |

BET 2019-02-07

This may not be the final document as it requires additional review by Provider Manager and Supervisor for completeness.

**Corrective Action Plan Provider Response**

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| --- | --- | --- | --- |
| **Corrective Action Plan** |  | Corrective Action Plan  Timeframe | Date Completed |
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| **Outcome Summary:** | | | |

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| --- | --- | --- |
| Signed: | Reviewer | Date: |
| Signed: | Program Manager | Date: |
| Signed: | IDHS Program Administrator | Date: |
| Signed: |  | Date: |

# Provider Contact

**Finding/Corrective Action Plan (CAP) Completion Instructions**

**Responsible Bureau:** Employment & Training

**Reviewer(s) Name:**  What individuals is/are actually on site doing the review?

**Date(s) of Review:** Date(s) you are conducting the review

**Review Type:** Monitoring, Site/Technical Assistance, Desk, Unannounced Visit

**Provider Name:** What site are you visiting?

**Provider Contact Information:** What is the best contact number to reach the point of contact on site?

**Program Name:** WorkFirst, TANF JP, TANF Special Projects, TANF Supportive Services, Earnfare, SNAP JP, SNAP E & T Special Project, Snap E & T Supportive Service, Cook Earnfare, Downstate Earnfare and HCD Special Project

**Finding Statement (s):** Cite from contract or policy manual when there is an infraction or violation of contract.

**Factors contributing to the Finding:** State what the Provider did or what you observed.

**Recommendation(s):** You can make recommendations re: enhancements to program (structure, operation, suggestion for a different methodology, a meeting btw provider Manager and Agency, consider a qualified person to do the job, etc.

**Monitoring Report Submitted by (if applicable):** If it is a monitoring report visit with an attached report being done by the person seeking review and approval to the supervisor should be listed.

**Program Manager Name:** Identify the Program Manager or the designee to whom is signing off on the COA.

**Corrective Action Plans**

The Corrective Action Plan is a tool for the Provider Manager to bring the agency into compliance and correct the violating condition. If at all possible, Corrective Action Plans **should be** developed & secured the day of the visit/review.

CAPs should be able to identify a basic plan to correct the condition. Some things may require additional time to develop more concretely, others not as much time based on complexity of the issue. Corrective Action Plans 3 weeks or more should NOT be the norm. It will require immediate supervisory approval for CAPs that are recommended for 3 or more weeks. Follow Up visits and/or contacts will be required to document satisfaction and completion of a CAP. CAPs should become a part of their file and record.

It is imperative that the reviewer leave with a signed copy of what is discussed with the Provider. The Provider gets the copy and the reviewer takes the original.