(Appendix A)
PLAN OF IMPROVEMENT

Provider/FEIN#:_____ **Provider Staff** _____
(Name, title)

Region: _____ **Type of Review** _____

Date: _____ **Review Date(s)** _____

Issue Identified:
Improvement Activities:
Person(s) Responsible:
Time Frame:
Expected Outcome:
Achievement Date:

INSTRUCTIONS FOR COMPLETION OF PLAN OF IMPROVEMENT REVIEW FORM

1. Form should be completed upon receipt of plan of improvement from the Provider.
2. Form to include name of contract manager reviewing the form and date reviewed.
3. Form to include region, provider name and FEIN#.
4. Form must be reviewed and signed by Executive Director before returning to Provider.
5. Form must be returned to Provider within two weeks of receipt by DMH.

DEFINITIONS FOR PLAN OF IMPROVEMENT TOOL

1. **Provider/FEIN# -** Provider name and assigned FEIN#
2. **Provider Staff** – Provider staff name and title who completed the plan of improvement
3. **Region** – Assigned region for Provider
4. **Issue Identified -** Finding(s) from monitoring review; identified areas to correct
5. **Improvement Activities** – Action steps to eradicate issue(s) identified; step-by-step plans to correct
6. **Person(s) Responsible** – Name(s) of staff responsible to implement and monitor improvement activities
7. **Time Frame** – Beginning and end date for improvement activities to occur
8. **Expected Outcome** – What is expected to occur as a result of implementation of the improvement activities
9. **Achievement Date** – Date issue eradicated; outcome met