DDQR-006
10/2018

Illinois Department of Human Services
Division of Developmental Disabilities
Corrective Action Plan

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

Provider Address: _____ Phone:_____

Provider Contact Name / Title: _____Email:_____

Type of Review: ___Rule 116 ___CILA ___ Community Day Services ____ Child Group Home

1 **Finding** (Include item number from review report to facilitate matching your corrective action with the review finding)	2 **Corrective Action** Corrective action must include: * Steps to correct the specific concerns identified by reviewers; * Steps to identify and correct similar issues which may be present within the agency but not specifically identified by the reviewers.	3 **Quality Assurance and Monitoring** Include steps to monitor status and prevent recurrence of similar problems in the future. Each corrective action step in column 2 must have corresponding quality assurance/monitoring activity listed in this column.	4 **Name and Title of Responsible Person** Ensure each corrective action step in column 2 has the name and title of the person responsible for coordinating corrective action and monitoring for quality assurance.	5 **Target Date for Completion** If multiple actions are associated with a finding, list target date for each action. All corrective action (listed in column 2) must be completed within 60 days of the review exit unless an extension is granted by BCS. (See exit letter for details.)

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Executive Director:_____ Date:_____
Signature