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|  | **Tennessee Department of Human Services**  **Adult Protective Services Sub-Recipient Corrective Action Plan** |

**Instructions**: Please complete form in full. Attach additional documentation, if necessary. Form must be signed by the agency’s authorized signatory. Submit form as a PDF to the appropriate email: [ssbg.dhs@tn.gov](mailto:ssbg.dhs@tn.gov), [crest.dhs@tn.gov](mailto:CREST.DHS@tn.gov), or [crevaa.dhs@tn.gov](mailto:crevaa.dhs@tn.gov).

**Section A. Institution Information**

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| Name of Agency: | Agreement No. |
| Mailing Address: | |

**Section B. Responsible Principal(s) and/or Individual(s)**

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| --- | --- |
| Name and Title: | Email Address: |
| Name and Title: | Email Address: |

**Section C. Corrective Action Plan Detail**

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| Date Issued: | Due Date: | Date submitted back to program: |
| Where will the Corrective Action Plan documentation be retained? | | |
| How will staff be (re)informed of the policies and procedures implemented to address the finding (Example: handbook, training, etc.)? | | |

**Section D. Findings**

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**Section E. Corrective Measures**

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| Describe the **step-by-step** procedures that will be implemented to correct the finding: |
| Date procedures will be implemented: |
| Recurrence schedule (e.g., daily, monthly, etc.): |
| Detail how staff will be informed of the above procedures (e.g., handbook, training, etc.): |
| Provide supporting documentation (e.g. copies of a new policy, staff training signature pages, etc.), and indicate where documentation will be retained: |

**Section F. Certification**

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| I certify by my signature below that I am authorized by the institution to sign this document. As an authorized representative of the institution, I fully understand the corrective measures identified above and agree to fully implement these measures within the required time frame.  I also understand that failure to fully and permanently correct the findings in my institution’s Program may result in termination from the program and in the placement of the institution and its responsible principals on the Disqualified List maintained by the U.S. Government and/or the State of Tennessee. | |
| Name of Authorized Signatory: | Title: |
| Signature of Authorized Signatory: | Date: |

**Section G. Approval (For State Use Only)**

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| Plan has been approved, no modifications required | |
| Plan requires corrections/modifications:  Notes: | |
| Grants Director or Designee Signature : | Date: |