MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)

CORRECTIVE ACTION PLAN (CAP)

DISTRICT NUTRITIONIST: _____

Program	Name of Sponsor:	Sponsor Number:
☐ CACFP ☐ SFSP		

Name of Center/Site:	Name of Authorized Representative:

Location where CAP documentation (written policies and staff training documentation) will be maintained:

Complete form and email to:
District Nutritionist as instructed in the letter
OR mail to:
Missouri Department of Health and Senior Services
Community Food and Nutrition Assistance
P.O. Box 570
Jefferson City, MO 65102

Director's Name:

Director's Date of Birth:

Owner or Board Chairman's Name:

Owner or Board Chairman's Date of Birth:

FINDING (as noted in the letter or on the report)	ACTIONS TO FULLY AND PERMANENTLY CORRECT THE FINDING	WHO IS RESPONSIBLE	CHECK IF THERE IS A WRITTEN POLICY	DATE OF EXPECTED COMPLETION	DATE STAFF WILL BE TRAINED ON PROCEDURE
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			☐		
			☐		

COMPLETED BY (PRINTED NAME):	SIGNATURE:	DATE: