Corrective Action Plan (CAP) Response Form

Child and Adult Care Food Program

Name of Center/Sponsor: _____CACFP Contract Number: _____

Name of Director: _____Director's Date of Birth: _____

Name of Owner or Board Chairperson: _____Owner or Board Chair's DOB: _____

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

FINDING (as noted in the report or letter)	**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**

Date CAP submitted via fax to 1-573-526-3679: _____ or
Date CAP mailed _____ to: Missouri Department of Health & Senior Services, Bureau of Community Food & Nutrition Assistance,
P.O. Box 570, Jefferson City, MO 65102
Date CAP received by MDHSS-BCFNA _____ Date/Time CAP faxed/given by Support (initials) to Nutritionist_____
Date CAP returned to Center/Sponsor, **if CAP deemed inadequate** _____ Date CAP Revisions received by MDHSS-BCFNA_____
Date CAP determined adequate by Nutritionist _____ Date Final CAP Scanned/Moved to District Folder on O drive_____
Additional Actions or Comments _____
_____