



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CORRECTIVE ACTION PLAN (CAP)

DISTRICT NUTRITIONIST: _____

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