CORRECTIVE ACTION PLAN

Participant Name: Johnny Sample	
Participant ID Number: 0011111	
Representative (if applicable): Josephine Sample	
Phone Number: xxx-xxx-xxxx **Participant** xxx-xxx-xxxx **Representative**	
Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s) 87, 89.)	
1. Timesheets/invoices were submitted for hours and/or amounts not in accordance with the approved Purchasing Plan resulting in a negative balance of -$9,306.00 as shown on the August/2010 Monthly Statement.	
Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)	
A. The participant/representative will develop a Purchasing Plan using the approved CDC+ monthly budget amount of $2,482.31 to be submitted to the consultant by 10/5/10 to have an effective date of 11/1/2010. The participant/representative will facilitate the reduction of the negative balance by having a portion of the service hours provided by unpaid natural support. a) Jim Ray will be authorized to provide 55 hours of PCA/32 monthly @ $15.00 hourly rate per month or 12.75 hours of PCA/32 @ $15.00 hourly rate per work week as paid support. Approximately 25 hours monthly will be provided as unpaid natural support. b) Phil Jones will be authorized to provide 24 hours of PCA/32 monthly @ $12.00 hourly rate per month or 5.5 hours of PCA/32 @ $12.00 hourly rate per work week as paid support. Approximately 26 hours monthly will be provided as unpaid natural support. c) Sara Jones will be authorized to provide 35 hours of PCA/32 monthly @ $12.00 hourly rate per month or 8 hours of PCA/32 @ $12.00 hourly rate per work week as paid support. Approximately 25 hours monthly will be provided as unpaid natural support. d) The participant/representative will not be purchasing any Respite services during the duration of this CAP. e) No special purchases will be approved to be purchased through the Savings Section for the duration of this CAP unless indicated by APD Staff. f) The unrestricted funds shown on the Savings Section page of the 11/1/2010 Purchasing Plan in the amount of $778.38 (or more if there is an increase in the monthly budget amount on future purchasing plans developed during the duration of this CAP) will be used to reduce the negative balance to 00.00. g) The participant/representative will develop a purchasing plan update or purchasing plan change whenever necessary in accordance with established CDC+ guidelines.	
Monthly Updates (to be completed at time of monthly contact with participant/representative). Consultant to indicate if each action step has been completed as described above. If action step was not completed as indicated, consultant to explain reason for noncompliance and action taken to rectify situation. Date each entry, initial and submit to Area Liaison.	
Date and Consultant Name	Update
Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s) 73, 87.)	
2. Mismanagement of CDC+ Monthly Budget. a. Overtime consistently paid to providers b. Monthly Statements were not reviewed and/or reconciled	

CORRECTIVE ACTION PLAN

Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)

A. The participant/representative will only submit hours on times sheets or amounts on vendor invoices that are in accordance with the current approved Purchasing Plan effective 11/1/2010 and in compliance with this CAP.
B. The participant/representative will track all hours of service provided by all authorized providers during any given month on a calendar to ensure the services that are being provided and submitted for payroll do not exceed the authorizations on the Purchasing Plan effective 11/1/2010 and are in compliance with this CAP.
C. The participant/representative will provide to the consultant (within 24 hours of the end of every two bi-weekly pay periods) copies of the completed/signed time sheets that were used to submit for payment during the two bi-weekly pay period to be in compliance with this CAP.
D. The participant/representative will review and reconcile each monthly statement to ensure spending is in accordance with the current approved Purchasing Plan and is in compliance with this CAP.
E. The consultant will review each monthly statement and the time sheets provided by the participant/representative to ensure spending is in accordance with the current approved Purchasing Plan and are in compliance with this CAP.

Monthly Updates (to be completed at time of monthly contact with participant/representative). Consultant to indicate if each action step has been completed as described above. If action step was not completed as indicated, consultant to explain reason for noncompliance and action taken to rectify situation. Date each entry, initial and submit to Area Liaison.

Date and Consultant Name	Update

Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s) 74, 91.)

3. No documentation in employer file to support the hours submitted on time sheets or the amount submitted for vendor invoices.
   a. Participant/representative failed to provide proof of time sheets/invoices upon request by Consultant or APD Staff.

Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)

A. The participant/representative will be properly trained using the CDC+ Participant Notebook/Appendix by APD Area Staff to include purchasing plan/quick update development, purchasing plan/quick update submission guidelines/deadlines, time sheet/invoice payroll submission and how to set up employer file to retain the required by documents by 11/14/2010.
B. The participant/representative will set up an employer file with 5 days of receiving the training provided by APD Area Staff.
C. The participant/representative will retain copies of all time sheets, invoices, tracking calendars and other CDC+ documents as required by the guidelines of CDC+ and make such documents available upon request.

Monthly Updates (to be completed at time of monthly contact with participant/representative). Consultant to indicate if each action step has been completed as described above. If action step was not completed as indicated, consultant to explain reason for noncompliance and action taken to rectify situation.

CORRECTIVE ACTION PLAN

Date each entry, initial and submit to Area Liaison.	
Date and Consultant Name	Update

Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s) 62, 68, 79.)

4. Providers were hired and began working prior to being authorized on an approved purchasing plan or to be paid to provide services.

Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll, by the 15th of each month, by ____date, etc.)

A. The participant/representative will be trained by APD Area Staff using the Participant Notebook/Appendix the steps of hiring and enrolling a new provider with the Fiscal Employer Agent (F/EA) by 11/14/2010.
B. The participant/representative will not allow providers to begin providing services until the provider has been authorized on a purchasing plan, enrolled with the F/EA and have been assigned an ID#.

Monthly Updates (to be completed at time of monthly contact with participant/representative).
Consultant to indicate if each action step has been completed as described above. If action step was not completed as indicated, consultant to explain reason for noncompliance and action taken to rectify situation.
Date each entry, initial and submit to Area Liaison.

Date and Consultant Name	**Update**

Description of Problem or Issue (Please Refer to the CDC+ Notebook, page(s) Notebook Appendix Section D #7.)

5. An Emergency Backup Plan as required by Medicaid Services 1915j has not be developed.

Action Steps required to fix the problem or issue stated above. Include responsible person for completing each action step and timeline for completion (i.e. bi-weekly at the end of each payroll,

CORRECTIVE ACTION PLAN

by the 15th of each month, by ____date, etc.)

A. The participant/representative will develop an Emergency Backup Plan (Appendix D) by 11/1/2010, retain a copy in employer file and submit to Consultant to be retained in the participant's Central File.

Monthly Updates (to be completed at time of monthly contact with participant/representative). Consultant to indicate if each action step has been completed as described above. If action step was not completed as indicated, consultant to explain reason for noncompliance and action taken to rectify situation. Date each entry, initial and submit to Area Liaison.

Date and Consultant Name	Update

CAP will be monitored until all corrections to the identified problems have been successfully met.

I acknowledge that I will not exceed the spending limits set forth in this Corrective Action Plan. (Initial)

Failure to comply with the stated action steps to achieve correction of the identified problem(s) within established timeframes may result in the participant's disenrollment from the CDC+ program and return to the DD/HCBS waiver.

Implementation Date: Review Date: Date Problem Resolved:

Participant/Representative Signature:_____ Date:

Consultant Signature:_____ Date:

Area APD Liaison Signature:_____ Date:

Central APD Office Signature:_____ Date: