# *OSPI CACFP Administrative Review (AR) Corrective Action Plan (CAP)*

| | | | |
|---|---|---|---|
| **Sponsor Name** | | **WINS ID** | |
| **Date of Review** | | **CAP Due Date** | |
| **Program Specialist** | | **Email / Phone** | |
| **Fiscal Action Required?** | ☐ **Yes** ☐ **No** | **Amount Due** | **$** |

## Purpose:

A Corrective Action Plan (CAP) is written documentation detailing steps taken to correct findings identified during a CACFP review. The purpose of the CAP is for the Sponsor to explain how the finding(s) will be permanently corrected and to ensure ongoing compliance with program requirements. The CAP document serves as formal record for both the sponsor and OSPI that corrective actions have been reviewed, approved, and implemented. Upon subsequent reviews, if OSPI determines the findings have not been permanently corrected, the Sponsor may be determined seriously deficient in their operation of the CACFP.

## A Corrective Action Plan (CAP) must clearly identify:

- **What** processes and procedures will be implemented to correct the finding?
- **Who** is responsible for implementing process and internal controls?
- **How** will the facility ensure the processes and procedures are followed consistently to prevent recurrence?
- **When** will the processes and procedures be implemented and at what frequency?
- **Where** will the documentation will be retained, demonstrating continued compliance?

Sponsors will be notified when submitted CAPs are approved. If a CAP is denied and time remains before the original CAP due date, the Sponsor may correct and resubmit the CAP. If the due date has passed, Sponsors may receive a Notice of Serious Deficiency and/or be prevented from renewing their CACFP application.

## Administrative Review Finding Details

(Completed by OSPI)

| | |
|---|---|
| Finding # | |
| Finding Description | |
| Code of Federal Regulation CFR | |
| Required Training | |
| Required Documentation | |
| OSPI Assigned CA: | |

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**Who is ultimately responsible for implementing the process and internal controls? Include titles and roles.**

**How will the facility ensure the processes are followed consistently to prevent recurrence?**

**When will the processes and procedures be implemented and at what frequency?**

**Where will the documentation be retained?**

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(Completed by OSPI)

**Assigned Training completed:** ☐ Yes ☐ No ☐ NA

**Corrective Action documentation received (ex, revised menu):** ☐ Yes ☐ No ☐ NA

**OSPI Approved**: ☐ Yes ☐ No ☐ Returned **Approval Date:**

**If returned, what detail is needed:**



**Sponsor Name:**

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# *Corrective Action Plan Signature Page*

***Sponsor Certification:***

☐ This submitted corrective action plan (CAP) addresses areas of non-compliance found during our CACFP administrative review. I understand that if during a subsequent review OSPI determines this CAP has not been fully implemented to permanently correct the issue(s) of non-compliance, then a Notice of Serious Deficiency or Propose to Terminate Letter could be issued which may result in the facility or sponsor being terminated from the CACFP.

☐ I understand if a fiscal action for an overpayment has occurred as a result of this review, corrective action includes repayment of the total fiscal action amount. If an outstanding balance remains unpaid, my organization may be determined seriously deficient and a proposal to terminate the permanent agreement may be issued.

**Note: CAP must be signed by all Responsible Individuals * If additional signatures are needed, please add another page.**

Responsible Official Signature

Responsible Official Name:

Title: Date:

Responsible Official Signature

Responsible Official Name:

Title: Date:

Responsible Official Signature

Responsible Official Name:

Title: Date:

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***OSPI CAP Review and Approval*** **Was CAP received by the assigned due date (2 weeks from assignment)?** ☐ Yes ☐ No

| **Corrective Action Plan Timeline** | | **Returned to Sponsor to correct finding #:** |
|---|---|---|
| **Date CAP Assigned** | | |
| **Date CAP Returned** | | |
| **Date CAP Returned** | | |
| **Date CAP Returned** | | |
| **Date CAP Approved** | | |

**CAP Status:** ☐ Approved ☐ Approved with Revisions ☐ Not Approved

_____ _____

**Specialist Signature** **Date**



**Sponsor Name:**