Corrective Action Plan (CAP) Form

Original Date Sent to My Path Provider: Click here to enter a date.

Please complete the Root Cause Analysis, Action Plan, Monitoring Plan, and sign and date in the spaces provided below. This CAP is due to IEHP within 30 calendar days of receipt. If you have any questions regarding this CAP, please contact IEHP My Path Team at: dgmypathteam@iehp.org

File Month/ Year	*Type*	*Findings*	**Root Cause Analysis** (to be completed by Provider)	**Action Plan** (to be completed by Provider)	**Monitoring Plan** (to be completed by Provider)	*CAP Accepted (Y/N)*	*Comments*

I understand that I have a responsibility to report any areas where activities are not in place to meet the actions or monitoring noted above, and that an additional audit by the health plan may be undertaken to ensure compliance.

_____ _____

Printed Name of Individual Attesting to CAP Response **Title of Signing Individual**

_____ _____

Signature of Individual Attesting to CAP Response **Date**