Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living

Home and Community Based Services
Corrective Action Plan

Participant: | Guardian: | Case Manager/ Service Advisor:

Is participant in Participant Directed Services? ○ Yes ○ No

State Issue:

Regulation/ Policy Violation:

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Agreed Upon Resolution:	
Potential Consequences:	
Prevention:	

If issue stated in Corrective Action Plan is not resolved within _____ days from the date of signature, possible termination from Participant Directed Services may be pursued. Failure to reach an agreed upon resolution may result in request for termination from Participant Directed Services.

Participant Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Case Manager/ Service Advisor Signature: _____ Date: _____