Children's Board of Hillsborough County

Provider Improvement Plan Form – FY 2018

__/__/__Contract Issue __/__/__ Performance Improvement[1] —/__/__ Program of Concern[2] - Completion Date:

Provider Agency:
Sub-Contractor:
Program Name:

CBHC Contract Manager:
CBHC Fiscal Representative:

Background / Issue(s) Requiring Action:

Final Result:

Strategies to Achieve Desired Result	Action Steps	Responsible Parties	Interim Reporting Date(s)	Due Date[3]	Completion Date	Progress Notes Including Final Result

CBHC Signature _____ **Date: ___ / ___ / ___**

Printed Name _____

Provider Signature _____ **Date: ___ / ___ / ___**
Authorized Official
Printed Name _____

[1,2] Programs at the Provider Improvement Plan & Program of Concern levels will be reported to the Provider Agency Board of Directors & CBHC Board.

[3] Due Dates cannot be changed without prior CBHC approval.