

Children's Board of Hillsborough County

Provider Improvement Plan Form (last revision January 2018)

___/___/___ Contract Issue ___/___/___ Performance Improvement¹ ___/___/___ Program of Concern² - Completion Date:

Provider Agency:

CBHC Contract Manager:

Sub-Contractor:

CBHC Fiscal Representative:

Program Name:

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: ___ / ___ / ___

Provider Signature _____ Date: ___ / ___ / ___

Printed Name _____

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.