



Illinois State Board of Education

100 North First Street, E-222
Springfield, Illinois 62777-0001

NITA M. LOWEY
21ST CENTURY COMMUNITY LEARNING CENTERS
PROGRAM CORRECTIVE ACTION FORM

WELLNESS DEPARTMENT

APPLICANT NAME / FISCAL AGENT	REGION, COUNTY, DISTRICT, TYPE CODE (RCDT)
ADDRESS (Street, City, State, Zip Code)	
COHORT YEAR/GRANT NUMBER	TELEPHONE (Include area code)
CONTACT PERSON	EMAIL
SELECT THE CORRECTIVE ACTION BOX RELATED TO NON-COMPLIANCE: <input type="checkbox"/> A. PROGRAM ORGANIZATION <input type="checkbox"/> B. PROJECT DESIGN <input type="checkbox"/> C. ACADEMIC PROGRAMMING <input type="checkbox"/> D. BUILDING SUPPORTIVE RELATIONSHIPS IN AFTER SCHOOL <input type="checkbox"/> E. DATA COLLECTION <input type="checkbox"/> F. FISCAL <input type="checkbox"/> G. QUALITY ASSURANCE	

CORRECTIVE ACTION PLAN: Please use a separate sheet for each Corrective Action

A.	Who will be responsible for implementing the Corrective Action?
B.	What action(s) will be taken to correct the finding?
C.	What are the expected dates of implementation and completion?
D.	How will actions be documented?
E.	How will the results of the action be evaluated to determine of the improvement occurred?

<i>Print/Type the Name</i> of Project Director	<i>Signature</i> of Project Director	Date
<i>Print/Type the Name</i> of Administrator	<i>Signature</i> of Administrator	Date