**Enrollment Improvement Plan**

|  |  |
| --- | --- |
| **Name (Person/Subrecipient) Responsible** |  |
| **Email (Person/Subrecipient) Responsible** |  |
| **Phone (Person/Subrecipient) Responsible** |  |
| **Dates of Correction or Request** |  |
| **Grant Award(s)** |  |
| **Family Support Consultant** |  |

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| --- | --- | --- |
| **Enrollment Improvement Plan** | | |
| **Identify Challenge Towards Enrollment** | | |
| Recruitment | | **Please include any extenuating circumstances** |
| Enrollment | |  |
| Staffing | |
| Other (Please specify) |  |

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| **Previous Efforts: Have there been any previous attempts to address the challenges towards enrollment?** |
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| **Goals and Outcomes** |
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| **Targeted Action Steps** |
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| --- |
| **Estimated Date of Completion** |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Grantee Representative Printed Name** | |  | **Title** |  | | |
| **Grantee Representative Signature** |  | | | | **Date** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Model TA/ Nurse Consultant Review** | | | |
| **Name & Title** |  | **Date** |  |
| **Comments** |  | | |

|  |  |  |
| --- | --- | --- |
| **Status: *To be completed by: Family Support Consultant*** | | |
| Approved | | **Date** |
| Returned for additional information | | **Date** |
| **Reason for Return:** |  | |