CRITICAL INCIDENT

Complete and submit **immediately** upon occurrence for incidents that occur in a home and community-based long-term care service delivery setting including community-based residential alternatives other than assisted living facilities; other HCBS provider sites; and an enrollee's home if the incident is related to the provision of HCBS. **DO NOT SKIP ANY FIELDS EXCEPT WHERE INDICATED.**

CRITICAL INCIDENTS CARRY A FINE OF ($500) IF SUBMITTED MORE THAN 24HRS AFTER PLAN WAS NOTIFIED.

Health Plan Information:	
Health Plan Name:	- Choose One-
Health Plan Medicaid ID #:	
Health Plan Medicare ID #:	
Plan Identifier:	- Choose One-
Today's Date (MM/DD/YYYY):	
Name of individual completing the report and position:	

Health Plan Staff Information:	
CM Name:	
CM Supervisor Name:	
Quality Reviewer Name:	

Enrollee Information:	
First Name:	
Last Name:	
Date of Birth (DOB):	
Sex:	
Enrollee Medicaid ID #:	
Region #:	
County of Residence:	

Incident Information:	
Incident Date:	
Date Reported to Plan:	
Incident Location:	

Facility Information (Skip if 'Incident Location' is not 'Facility'):	
Facility Type:	
Facility License #:	
Facility Name:	
Facility Address:	
City:	
County:	
State:	
Medicare only! If incident occurred in a hospital,	
Hospital Name:	
Admission Date and Time:	
Admitting Diagnosis Code(s):	

Home Information (Skip if 'Incident Location' is not 'Home'):	
Homeowner Name (First, Last):	
Home Address:	
City:	
County:	
State:	

Transport Information (Skip if 'Incident Location' is not 'Transport'):	
Company Name:	
Nearest Street Address to Incident:	
City:	
County:	
State:	

Other Location Resulting from Elopement (Skip if 'Incident Location' is not 'Other Location…'):	
HCB Provider/Caregiver Name:	
Nearest Street Address to Incident:	
City:	
County:	
State:	

	Critical Incident Type (Select All That Apply):
	Enrollee death that is otherwise unexpected.
	Enrollee death by homicide.
	Enrollee death by suicide.
	Enrollee death by abuse, neglect, or exploitation.
	Enrollee brain damage.
	Enrollee spinal damage.
	Permanent disfigurement.
	Fracture or dislocation of bones or joints.
	Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition.
	Any condition requiring surgical intervention to correct or control.
	Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care.
	Any condition that extends the patient's length of stay.

	Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.
	Suspected abuse, neglect, or exploitation.
	Injury or major illness as a result of care provider.
	Sexual Battery.
	Medication error.
	Suicide Attempt.
	Altercations requiring medical intervention.
	Elopement.
	Medicare Only – Any surgical procedures being performed on the wrong patient.
	Medicare Only – Any surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient.

Individuals Involved (Add additional involved parties in the narrative section if necessary):	
First involved party is mandatory	
First Name:	
Last Name:	
Role:	
Involvement (brief description):	
License # (Mandatory if licensed):	
Where to locate the witness:	
Second involved party (if applicable)	
First Name:	
Last Name:	
Role:	
Involvement (brief description):	
License # (Mandatory if licensed):	
Where to locate the witness:	
Third involved party (if applicable)	
First Name:	
Last Name:	
Role:	
Involvement (brief description):	
License # (Mandatory if licensed):	
Where to locate the witness:	

Investigation:	
Has the Issue been Resolved?	
Resolution Date (If resolved):	

Circumstances of the Incident (Narrative of Facts):	
[Enrollee's First and Last Name] is a [Age] [Sex] who had an incident on [Date] that [did nor did not] involve a HCBS provider [Name the HCBS provider type as PCA, Homemaker, ACC, Transportation Vendor, etc.]; and [did or did not] involve physical injury. **The enrollee has the following primary and secondary diagnoses: [List diagnoses]; and is on the following prescribed drugs: [Enter just the names of the drugs, not the dosages].** **This enrollee [does or does not] live alone and [is or is not] bedbound.** **The enrollee has [cognitive, visual, hearing, ambulation, etc.] impairments.** **This incident was reported to Plan by [Person's Name], who is the {Enrollee, Enrollee's spouse, child, friend, etc.] on [Date]. Plan was notified that [Incident Description]** **There [was or was not] another person witness to the incident. [Name person and how where to locate the witness].** **The physical injury report is [Type of injury incurred], resulting in [No treatment, Minor treatment, Visit to doctor, transport to the ED].** **The enrollee is (present status as a result of the injury) [Treated and recovering, Inpatient hospital, Well and Unaffected, etc.].** **[If no physical injury was sustained, cite what exactly occurred as a result of the incident].**	
Medicare Only	
Was a Dr. called? [Include a brief statement of the physician recommendation.]	

Corrective Action Summary (Corrective or Proactive Actions Taken):	
The Care Manager took these steps following the report of this incident: [Filed with the Plan Incident Report Agent; Filed a Complaint with APS, DCF, or Plan Risk Manager]. **[Describe any additional action(s) taken to reduce risk to member].**	

	Select if this met the requirements for Plan to report as a Critical Incident to the Agency.