

**Critical Incident Report Form**

Member Name  Member ID# 

Address Line 1  City 

Address Line 2  County 

Phone  Date of Birth 

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| **Incident Details** |
| Date of Incident  [ ]  Check if date of incident is approximateLocation where incident took place Person reporting incident Address Phone Relationship to member Date and time incident report completed Additional Information:  |
| **Type of Incident (Check all that apply.)** |
| [ ]  Suspected physical, mental, sexual abuse and /or neglect/exploitation of a member[ ]  Inappropriate/unprofessional conduct by a provider involving a member[ ]  Serious Injury sustained by a member[ ]  Unexpected death of a member | [ ]  Suspected theft or financial exploitation of a member [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If Hospitalized, Date of Admission  Date of Discharge Description of Event:      If the event involved physical, mental, sexual abuse and/or neglect/exploitation, provide the following details:Type Date Time Length  |
| Name(s) and role(s) of all involved in this incident:       |
| Names of those who witnessed this incident:       |
| **Person Filing and Reporting Incident** |
| Name Agency Phone Number Email Address:  |
| **Medical Treatment Provided** |
| Describe any medical treatment provided to member:      Medical treatment provided by:Name Address Phone  |
| Contacts made on behalf of member: (examples: Ombudsman, Protection & Advocacy, Law Enforcement, Child Protective Services, Adult Protective Services, etc.):      |
| Names and relationships of those contacted on behalf of the person involved in the Incident (legal representative, relatives, friends, or other informal supports):      |
| Action taken to resolve concerns by Case Manager or Care Coordinator:     Medical Director follow up actions:      |

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| **Follow Up: Care Coordinator/Quality Monitoring and Oversight (DMMA)** |
| Date Report Received  |
| Concerns identified by Care Coordinator/Quality Monitoring and Oversight (DMMA):       |
| Incident closed?: Yes [ ]  No [ ] Action Taken by DMMA/Resolution/Concerns:      Date Action Taken Follow-Up Planned:      Signature  Date**Chief of Managed Care Operations or Designee** |