

**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 approximate  Location 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** |