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| **Patient Information** |
| **Provider One #** | Click here to enter text. | **Date of Birth** | Click here to enter text. |
| **Last Name** | Click here to enter text. | **First Name** | Click here to enter text. |
| **County of Residence** | Click here to enter text. | **Date of Report** | Click here to enter text. |
| **County of Incident** | Click here to enter text. | **Other Information** | Click here to enter text. |
| **Incident Information** |
| **Date of Incident** | Click here to enter a date. | **Time of Incident (if known)** | Click here to enter text. |
| **Facility** |  | **Facility Contact Info** |  |
| **Level of Care** | [ ]  Inpatient [ ]  Residential Tx [x]  Crisis Stabilization [ ]  IOP [ ]  Outpatient [ ]  Other (please specify) Click here to enter text. |
| **Location of Incident (if known)** | Click here to enter text. |
| **Type of Incident (Required by MCOs)** | Incidents that occurred **to** a member/client while they were within a contracted behavioral health facility, FQHC or by an independent provider |
|  |[ ]  Abuse/Neglect/Sexual or Financial Exploitation |[ ]  Death |
|  |[ ]  Severely adverse medical outcome or death occurring within 72 hours of transfer from a contracted behavioral facility to a medical treatment facility (new requirement for January 2021) |  |  |
|  | Incidents that occurred **by** a member/client (allegedly committed the following) – member must have a current behavioral health diagnosis or history of behavioral health treatment in the previous 365 days |
|  |[ ]  Homicide or Attempted Homicide |[ ]  Arson |
|  |[ ]  Assault or action resulting in serious bodily harm which has the potential to cause disability or death |[ ]  Kidnapping |
|  |[ ]  Sexual Assault |  |  |
|  | Other Incidents |
|  |[ ]  Unauthorized leave from a behavioral health facility during an involuntary detention |[ ]  Any event that has or will attract media attention – include link to media source in description |
|  |[ ]  Incident posing a credible threat to the member’s safety |[ ]  Suicide Attempt |
|  |[ ]  Poisoning/Overdose – unintentional or intention unknown |  |  |
| **Other Incidents (Required by ASO or another Entity/Provider)** | [ ]  Elopement (resulting in patient death or serious injury) | [ ]  Suicide Attempted/Completed | [ ]  Sexual behavior, abuse, or assault on a member or staff within or on the grounds of a healthcare setting |
|  | [ ]  Fall (resulting in death or serious injury while on the grounds of a healthcare setting) | [ ]  Any serious injury in a treatment setting resulting in urgent/emergent interventions | [ ]  Self-inflicted harm (resulting in death or serious injury while in treatment) |
|  | [ ]  Accident (resulting in death or serious injury within a healthcare setting) | [ ]  Medications/Treatment error (resulting in death or serious injury) | [ ]  Unscheduled event that results in the evacuation of a program/facility |
|  | [ ]  Unplanned transfers to a medical unit | [ ]  Other occurrences, not listed, representing actual serious harm to a member (provide explanation) Click here to enter text. |
|  | [ ]  Death or serious injury of a staff or public citizen(s) at a licensed site | [ ]  Bomb threat | [ ]  Credible threat to a staff member that occurs at a licensed facility resulting in a report to LE, a restraining/protection order, or a workplace safety plan |
|  | [ ]  Alleged abuse or neglect of a client of a serious or emergency nature, by a workforce member or another individual in services | [ ]  Theft or loss of client data in any form | [ ]  Any incident reported to the Medicaid fraud unit |
|  | [ ]  A natural disaster or outbreak of a communicable disease that presents a substantial threat to licensed facility operation or client safety | [ ]  Breach or loss of client data considered reportable under HITECH that would allow for unauthorized use of client PHI | [ ]  A life event that requires an evacuation or that is a substantial disruption to the facility |
| **Description of Incident** | Click here to enter text. |
| **Other Individuals Involved – complete this section if you know of other individuals involved in the incident** |
| **Last Name** | Click here to enter text. | **First Name** | Click here to enter text. |
| **Relationship** | Click here to enter text. | **How were other individuals involved?** | Click here to enter text. |
| **Other Agency/Facilities Notified – complete this section if you know of any agencies/facilities notified (i.e. APS/CPS/local police)** |
| **Date** | Click here to enter a date. | **Type of Agency or Facility Notified** | Click here to enter text. |
| **Reporting Information** |
| **Name of person reporting incident** | Click here to enter text. | **Provider Group/CCO/ASO/Other** | Click here to enter text. |
| **Date Submitted** | Click here to enter a date. | **Phone number of person reporting** | Click here to enter a date. |
| **Email address of person reporting** | Click here to enter a date. |  |  |
| **Other comments or information regarding incident** | Click here to enter text. |
| **Steps taken to ensure safety of member/client; current disposition of member/client: (**safety plans, wellness check, hospitalization, appointments, referrals) |  |