|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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  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) | | |  | | | | | | | | | |