

Instructions for the Incident Report

Date/Time of Incident: *Approximate date/time the incident occurred.*

Discovery Date/Time: *Approximate date/time the reporter discovers, or is told, of an incident but was not present or involved.*

Member Information: *Include information of the waiver member involved in the reported incident. The reporter will identify the waiver program the member is enrolled in, Medicaid ID number if known, preferred method of communication, and whether the member has a legal guardian.*

Location Type:

- Member's Home: *The incident took place at the waiver member's home*
- Licensed Residential Setting: *The incident took place at a licensed personal care home.*
- Community: *The incident took place outside of the waiver participant's home and in a community setting.*
- Day Center: *The incident took place at an Adult Day Health Center*
- Unknown: *The location of the incident could not be identified.*
- Other: *The incident took place at another location category not described above*

Person Injured: *Indicate whether the incident resulted in injury to the member*

Severity Scale: *Indicate the severity of the injury and/or incident*

Staff present or on-site: *Indicates whether staff witnessed or was involved in the incident*

Staff licensure type: *Indicate the licensure type of the staff involved*

Incident Type: *Select the incident type(s) associated with the event. The reporter may select multiple incident types if they relate to the same overall incident. Incident type definitions can be found in Medicaid Waiver Program Manuals.*

Note: If incidents of alleged abuse, neglect, or exploitation are selected, demonstration of notification to law enforcement, Adult Protective Services and HFRD, where applicable, is required in the Notification section.

Incident Description: *Description should include what happened before, during, and after the incident. Be as specific as possible, including first and last name(s) of any staff involved and specific dates and times (i.e. avoid using terms "yesterday", 1 month ago, etc.).*

Reporting Provider: *Include information regarding the reporting provider and contact person for any required follow-up by DCH.*

Are you a licensed agency/facility: *Indicate whether the reporting provider is a licensed facility or agency. If the reporter does not know the HFRD Facility ID (FACID), then it can be looked up by entering the licensed provider name in the Facility Name field. The address and FACID will auto complete once a provider name is selected from the drop down menu.*

Have you already filed a Facility Incident Report with HFRD: *If the reporting provider is a licensed facility or agency and has indicated that a Facility Incident Report has not been filed with HFRD, then this report will automatically be submitted to HFRD for intake and triage and a separate report will not need to be filed. If a Facility Incident Report has been filed ahead of the submission of the Incident Report, then date and method of notification become required.*

Am I the contact person to contact if there are questions about this report: *The individual that witnessed or discovered the incident is ultimately responsible for the information included in the Incident Report, however, each provider agency is encouraged to designate an authorized individual to review the report for accuracy and completeness prior to submission to DCH and to respond to follow-up questions if needed.*

Case Management Provider is the reporting provider: *If the reporting provider is not the Case Management Provider, then contact information, date and method of notification become required.*

Notifications: *The reporter will notify all appropriate entities which varies depending on the incident type or location. Indicate the name of the person notified, the date and method of notification. Multiple entities for notification can be added.*

Instructions for the Follow-Up and Interventions Report

Incident Number: *Automatically generated unique identifier that links back to the Incident Report*

Member Name: *Name of the member involved in the incident*

Provider Name: *Name of the case management provider*

What did your agency do directly following the incident to make sure the individuals and staff were safe? *Include information describing what actions were taken to protect the waiver member's health, safety and welfare upon witnessing or discovering an incident and throughout the investigation*

What circumstances may have led to the incident? *Identify the circumstances or if risk factors existed prior to the incident that may have alerted staff to the potential for the incidence occurrence*

What steps will be taken to prevent a similar incident in the future: *Describe the interventions that the agency will implement to reduce or prevent a similar incident in the future*

Step begin date: *Identify the begin date*

Name of Person Responsible: *Identify individual responsible for implementation of the interventions*

Provide a description of the process for evaluating the effectiveness of the plan and anticipated timeline for completion of certain activities related to the intervention(s).