COLORADO
Department of Health Care Policy & Financing

HCBS Provider Critical Incident Information Form

Today's Date: _____ **Time of Incident:** _____

Case Manager Name: _____

Case Management Agency Name: _____

Client Name: _____

Client Medicaid ID: _____

HCBS Waiver Program: (check one)

- ☐ Children's HCBS
- ☐ Persons with Brain Injury
- ☐ Spinal Cord Injury
- ☐ Developmental Disabilities
- ☐ Childrens Extensive Support
- ☐ Children with Autism
- ☐ Community Mental Health Supports
- ☐ Elderly, Blind & Disabled
- ☐ Supported Living Services
- ☐ Children with Life Limiting Illness

Who reported incident to Case Manager?
Name: _____

Agency and Role: _____

Primary Incident Type: (check one)

- ☐ Death
- ☐ Abuse/Neglect/Exploitation
- ☐ Criminal Activity
- ☐ Serious Injury to Illness of Client
- ☐ Unsafe Housing/Displacement
- ☐ Damage to Client's Property/Theft
- ☐ Medication Management
- ☐ Missing Person
- ☐ Other High Risk Issues

Date of Incident: ___/_____/_____

Time of Incident: _____

Location of Incident: (check one)

- ☐ Alternative Care Facility (ACF)
- ☐ School
- ☐ Group Home
- ☐ Personal Residence
- ☐ Place of Employment
- ☐ Other_____
- ☐ Day Program
- ☐ Hospital
- ☐ Host Home
- ☐ In Community
- ☐ Transportation

Persons Involved in Incident: _____

Was anyone other than the client involved in the incident? ☐ Yes ☐ No
(*If yes is selected, complete the section below)*

Persons Involved and Role:

☐ Family Member
☐ Alleged Participant ☐ Alleged Perpetrator ☐ Witness ☐ Other

☐ Personal Care Provider
☐ Alleged Participant ☐ Alleged Perpetrator ☐ Witness ☐ Other

☐ Provider Staff
☐ Alleged Participant ☐ Alleged Perpetrator ☐ Witness ☐ Other

☐ Co-habitant
☐ Alleged Participant ☐ Alleged Perpetrator ☐ Witness ☐ Other

☐ Other _____
☐ Alleged Participant ☐ Alleged Perpetrator ☐ Witness ☐ Other

Description of Incident:

Please complete the items specific to incident type below.

DEATH

Death Type:

- ☐ Suicide
- ☐ Unexpected/Unexplained Death
- ☐ Anticipated Death/Natural Causes
- ☐ Homicide
- ☐ Accidental Death
- ☐ Other _____

ABUSE/NEGLECT/EXPLOITATION

Type of Abuse/Neglect/Exploitation: [check one]

- ☐ Self Neglect
- ☐ Caregiver Neglect
- ☐ Exploitation
- ☐ Inability to Give Informed Consent
- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Emotional Abuse
- ☐ Other _____

Source of Abuse/Neglect/Exploitation: [check one]

- ☐ Self
- ☐ Provider Staff
- ☐ Peer
- ☐ Family Member
- ☐ Co-Habitant
- ☐ Other _____

Did Abuse/Neglect/Exploitation Result in Hospitalization?

☐ Yes ☐ No

If Yes is selected, Where was client Hospitalized?

SERIOUS INJURY TO OR ILLNESS OF CLIENT

Serious Injury/Illness Type: [check one]

- ☐ Laceration requiring sutures/staples
- ☐ Fracture
- ☐ Dislocation
- ☐ Loss of Limb
- ☐ Other _____
- ☐ Serious Burn
- ☐ Skin Wound due to poor care
- ☐ Suicide Attempt
- ☐ Brain Injury

Cause of Injury/Illness: [check one]

- ☐ Fall
- ☐ Medical Condition
- ☐ Poor Care
- ☐ Seizure
- ☐ Accident
- ☐ Treatment Error
- ☐ Undetermined
- ☐ Other _____

Did Serious Injury/Illness Result in Hospitalization?

☐ Yes ☐ No

If Yes is selected, where was client Hospitalized?

DAMAGE TO CLIENT'S PROPERTY/THEFT:

Type of Loss: (check one)

- ☐ Damage to Property
- ☐ Theft of Property
- ☐ Deliberate Diversion of Medication
- ☐ Other _____

MEDICATION MANAGEMENT

Name of Medication _____

Medication Related Event Type: (check one)

- ☐ Medication Omission
- ☐ Wrong Dose
- ☐ Wrong Medication
- ☐ Wrong Time (>1hr. variance)
- ☐ Wrong Route of Administration
- ☐ Medication Refused
- ☐ Non-Compliance
- ☐ Other _____

Reason for Event: (check one)

- ☐ Administration Error
- ☐ Supply Exhausted
- ☐ Forgotten
- ☐ Refusal
- ☐ Prescription Unfilled
- ☐ Incorrect Chart Entry
- ☐ Other _____

Administered by/Set-up by: (check one)

- ☐ Consumer
- ☐ Provider
- ☐ Provider Set-up Only
- ☐ Provider Administration Only
- ☐ Family Member
- ☐ Other _____

Did the Medication Error Result in Hospitalization?

☐ Yes ☐ No

If Yes is selected, where was client Hospitalized?

OTHER HIGH RISK ISSUES

Risk Issue Type:

- ☐ Lost/Missing Person
- ☐ Suicidal Ideation/Attempt

☐ Loss of Home/Eviction
☐ Client Fraud
☐ Criminal Justice Involvement
☐ Victim of Crime
☐ Other _____

☐ Substance Abuse
☐ Provider Fraud
☐ Critical Service Interruption
☐ Abusive/Violent Behavior by Client

Why is this issue of particular risk to this person?

CRIMINAL ACTIVITY

Has the client been arrested/incarcerated?

☐ Yes ☐ No

If Yes is selected, what are the charges?

Criminal Activity: [check one]

☐ Assault and Battery
☐ Drug Possesion
☐ Probation/Parole Violation
☐ Other _____

☐ Domestic Violence
☐ DUI/DWI
☐ Theft/Larceny

MISSING PERSON

Has a missing person report been made to law enforcement?

☐ Yes ☐ No

If No is selected, why has a missing report not been made?

UNSAFE HOUSING/DISPLACEMENT

Is the client currently homeless?

☐ Yes ☐ No

If Yes is selected, what is being done to secure housing for the client?

Unsafe Housing/Displacement: [check one]

- ☐ Environmental Hazard
- ☐ Social Environment
- ☐ Other _____
- ☐ Eviction
- ☐ Structural Hazard

Action Steps Taken: ***Mark All That Apply***

Mandatory Reports Made:

- ☐ Mandatory Report to Adult Protective Services
  Worker taking report: _____
- ☐ Mandatory Report to Child Protective Services
  Worker taking report: _____
- ☐ Mandatory Report to Colorado Dept. of Public Health and Environment
  Worker taking report: _____

Additional Follow-up:

- ☐ Additional Follow-up with Client
- ☐ Additional Follow-up with Provider(s)
  Contact Name/phone: _____
- ☐ Additional Follow-up with Family Member
  Contact Name/phone: _____
- ☐ Additional Follow-up with Contractor
  Contact Name/phone: _____

Referrals Made:

- ☐ Referred to Law Enforcement
  Contact Name/phone: _____
- ☐ Referred to Emergency Department
  Contact Name/phone: _____
- ☐ Referred to Ambulance/Paramedics
  Contact Name/phone: _____
- ☐ Referred to Fire Department
  Contact Name/phone: _____
- ☐ Referred to Mental Health Provider
  Contact Name/phone: _____
- ☐ Referred to Primary Care Provider
  Contact Name/phone: _____

Notifications Made:

☐ Notification to Provider Agency
Contact Name/phone: _____

☐ Notification to Advocate/Ombudsman
Contact Name/phone: _____

☐ Notification to Client Representative/Guardian
Contact Name/phone: _____

☐ Notification to Other: specify
Contact Name/phone: _____

Additional Information: