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  ☐ Children with Autism
☐ Persons with Brain Injury  ☐ Community Mental Health Supports
☐ Spinal Cord Injury  ☐ Elderly, Blind & Disabled
☐ Children with Life Limiting Illness

Who reported incident to Case Manager?

Name: _____________________________________________

Agency and Role: ____________________________________

Primary Incident Type: (check one)

☐ Death  ☐ Damage to Client’s Property/Theft
☐ Abuse/Neglect/Exploitation  ☐ Medication Management
☐ Serious Injury to Illness of Client  ☐ Other High Risk Issues

Date of Incident: ____ / ____ / ______

Time of Incident: _______________

Location of Incident: (check one)

☐ Alternative Care Facility (ACF)  ☐ Day Program
☐ School  ☐ Hospital
☐ Personal Residence  ☐ In Community
☐ Other______________________________

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
- 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:**

<table>
<thead>
<tr>
<th>Type of Loss: (check one)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Damage to Property</td>
<td>☐ Theft of Property</td>
</tr>
<tr>
<td>☐ Deliberate Diversion of Medication</td>
<td></td>
</tr>
<tr>
<td>☐ Other ______________________________</td>
<td></td>
</tr>
</tbody>
</table>

**MEDICATION MANAGEMENT**

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>______________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medication Related Event Type: (check one)</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>☐ Medication Omission</td>
<td>☐ Wrong Dose</td>
</tr>
<tr>
<td>☐ Wrong Medication</td>
<td>☐ Wrong Time (&gt;1hr. variance)</td>
</tr>
<tr>
<td>☐ Wrong Route of Administration</td>
<td>☐ Medication Refused</td>
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<tr>
<td>☐ Non-Compliance</td>
<td>☐ Other ____________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for Event: (check one)</th>
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</thead>
<tbody>
<tr>
<td>☐ Administration Error</td>
<td>☐ Supply Exhausted</td>
</tr>
<tr>
<td>☐ Forgotten</td>
<td>☐ Refusal</td>
</tr>
<tr>
<td>☐ Prescription Unfilled</td>
<td>☐ Incorrect Chart Entry</td>
</tr>
<tr>
<td>☐ Other ____________________</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Administered by/Set-up by: (check one)</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>☐ Consumer</td>
<td>☐ Provider</td>
</tr>
<tr>
<td>☐ Provider Set-up Only</td>
<td>☐ Provider Administration Only</td>
</tr>
<tr>
<td>☐ Family Member</td>
<td>☐ Other ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did the Medication Error Result in Hospitalization?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

*If Yes is selected, where was client Hospitalized?*

<table>
<thead>
<tr>
<th>OTHER HIGH RISK ISSUES</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Risk Issue Type:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Lost/Missing Person</td>
<td>☐ Suicidal Ideation/Attempt</td>
</tr>
<tr>
<td>☐ Loss of Home/Eviction</td>
<td>☐ Substance Abuse</td>
</tr>
<tr>
<td>☐ Client Fraud</td>
<td>☐ Provider Fraud</td>
</tr>
<tr>
<td>☐ Criminal Justice Involvement</td>
<td>☐ Critical Service Interruption</td>
</tr>
<tr>
<td>☐ Victim of Crime</td>
<td>☐ Abusive/Violent Behavior by Client</td>
</tr>
<tr>
<td>☐ Other ______________________________</td>
<td></td>
</tr>
</tbody>
</table>
Why is this issue of particular risk to this person?

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: