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
- ☐ Children with Life Limiting Illness
- ☐ Children with Autism
- ☐ Community Mental Health Supports
- ☐ Elderly, Blind & Disabled

Who reported incident to Case Manager?

Name: _____

Agency and Role: _____

Primary Incident Type: (check one)

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

Date of Incident: ___/___/___

Time of Incident: _____

Location of Incident: (check one)

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

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:

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
- ☐ Substance Abuse
- ☐ Client Fraud
- ☐ Provider Fraud
- ☐ Criminal Justice Involvement
- ☐ Critical Service Interruption
- ☐ Victim of Crime
- ☐ Abusive/Violent Behavior by Client
- ☐ Other _____

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: