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
☐ Developmental Disabilities  ☐ Supported Living Services
☐ Childrens Extensive Support  ☐ 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
☐ Criminal Activity  ☐ Missing Person
☐ Serious Injury to Illness of Client  ☐ Other High Risk Issues
☐ Unsafe Housing/Displacement

Date of Incident: __ / __ / ____

Time of Incident: _____________

Location of Incident: (check one)

☐ Alternative Care Facility (ACF)  ☐ Day Program
☐ School  ☐ Hospital
☐ Group Home  ☐ Host Home
☐ Personal Residence  ☐ In Community
☐ Place of Employment  ☐ Transportation
☐ 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
- [ ] 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
- [ ] Skin Wound due to poor care
- [ ] Suicide Attempt
- [ ] Brain Injury
- [ ] Other ________________

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
- [ ] 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?

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 ☐ Domestic Violence
☐ Drug Possesion ☐ DUI/DWI
☐ Probation/Parole Violation ☐ Theft/Larceny
☐ Other ____________________________________

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:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________