



New Choices Waiver Incident Report Form

CLIENT'S NAME :	DOB: ____/____/____	<p><u>Please check the incident type below.</u></p> <p><i>The following incidents require immediate (same day) notification:</i></p> <p><input type="checkbox"/> Unexpected or accidental death</p> <p><input type="checkbox"/> Suicide attempt (does not include threats only)</p> <p><input type="checkbox"/> Incident expected to receive media, legislative or public scrutiny</p> <p><input type="checkbox"/> Compromised work or living environment requiring evacuation</p> <p><input type="checkbox"/> Person missing under suspicious or unexplained circumstances (Time of last known whereabouts: _____)</p> <p><i>The following incidents require notification within 24 hours or on the next business day:</i></p> <p><input type="checkbox"/> Injury (includes burns, choking, brain trauma, fractures, etc.)</p> <p><input type="checkbox"/> Abuse (physical or sexual)</p> <p><input type="checkbox"/> Neglect (caregiver neglect or self-neglect)</p> <p><input type="checkbox"/> Exploitation (by somebody in a relationship of trust)</p> <p><input type="checkbox"/> Waste, fraud or abuse of Medicaid funds</p> <p><input type="checkbox"/> Human rights violation</p> <p><input type="checkbox"/> Medication/treatment errors resulting in marked adverse side effects</p> <p><input type="checkbox"/> Law enforcement involvement resulting in charges being filed</p> <p><input type="checkbox"/> Other type of incident causing concern for safety</p> <p><u>Please answer the following 5 questions:</u></p> <p>1. Did the person sustain an injury as a result of the incident? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>2. Was the person treated in the ER and released the same day? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>3. Was the person admitted to the hospital? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>4. If 'yes' to #3, was the hospital admission directly related to the injury or was it for another medical reason or both? <input type="checkbox"/>Injury <input type="checkbox"/>Another medical reason <input type="checkbox"/>Both</p> <p>5. Is/was the person receiving hospice care? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	
FACILITY OF RESIDENCE NAME:	DATE OF INCIDENT:		
<input type="checkbox"/> N/A – not living in a facility)	TIME OF INCIDENT:		
CLIENT'S MAILING ADDRESS:			
WAS THE FAMILY/RESPONSIBLE PERSON NOTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Does this client have a legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No Guardian's name: _____		
LAW ENFORCEMENT NOTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date: _____	APS NOTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date: _____		
NARRATIVE DESCRIPTION OF INCIDENT			
<p>1. Location of incident:</p> <p>2. What happened?</p> <p>3. How was it discovered?</p> <p>4. Immediate actions taken:</p> <p>5. Any precipitating events? (illnesses, med changes, etc)</p> <p>6. Will there be any new safeguards as a result of this incident?</p>			
Provider Representative's Signature:	Phone & Email:	Title:	Date forwarded to case manager:
Case Manager's Signature:	Phone & Email:	Date Notified:	Date forwarded to BACBS:
BACBS Representative's Signature:	Phone & Email:	Date notified:	Date forwarded to SMA QA Unit: <input type="checkbox"/> N/A