Critical Incident Reporting Form

This form is to be used by UnitedHealthcare Community Plan providers to report to UnitedHealthcare Community Plan the occurrence of a reportable critical incident involving our members.

We must receive the form within 24 hours of discovery of the incident. Please complete it and fax it to the Quality Management Department along with any supporting documentation to 855-216-6408.

Upon learning of the occurrence of a reportable critical incident, please contact one of the following:

New Jersey Adult Protective Services (APS) – phone number: 609-588-6501
Office of the Ombudsman for the Institutionalized Elderly (OOIE) – fax number: 877-585-6995
Child Protection and Permanency Office (CP&P) and Disabled Child Protection and Permanency Office (DCP&P) – phone: 877-652-2873

SECTION 1: Member Information (complete all sections)		
Subscriber ID:	**Medicaid ID:**	**Member Name:**
DOB:	**Gender:**	**Member Address:**
UnitedHealthcare Community Plan Care Coordinator for member:		

SECTION 2: Critical Incident Information (complete all sections)	
Date/Time incident occurred:	**Date/Time Care Provider or UnitedHealthcare Community Plan representative (and others copied) first learned of incident (discovery):**
Date/Time reported to UnitedHealthcare Community Plan Clinical Quality Analyst:	
Who first reported incident to provider or UnitedHealthcare Community Plan representative? ☐ Member ☐ POA/Family ☐ Worker ☐ Other ______________________________	**Location of Incident:** ☐ Private Home ☐ Facility-Based Setting ☐ Community/General Public Area ☐ Other/Facility name: ________________________
Primary Medical Complexity: (check all that apply) ☐ Heart Condition (i.e. CVA, Hypertension, CHF) ☐ Muscular/Skeletal (i.e. Arthritis, Fracture) ☐ Neurological (i.e. Alzheimer's, MS, Head Trauma, Quadriplegia, Seizure Disorder) ☐ Psychiatric/Mood (i.e. Anxiety, Depression, Behavioral/Mental Illness, Psych Diagnosis) ☐ Pulmonary (i.e. Emphysema, Asthma, COPD) ☐ Sensory (i.e. Vision/Hearing Impaired) ☐ Infections (i.e. Pneumonia, TB, UTI) ☐ Other Diseases (i.e. Renal Failure, Cancer)	

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Provider Type:

☐ Community Living Facility Providers (Adult Facility Care, Assisted Living Services, Comprehensive Personal Care Home, Assisted Living Program, Community Residential Services)
☐ Day Service Providers (Social Adult Day Care, Structured Day Program, Supported Day Services, Medical Day Services – Pediatric and Adult)
☐ Home Care Providers (Home Based Supportive Care, Home-Delivered Meals, Chore Services, Medication Dispensing Device, Personal Emergency Response System (PERS), In-Home Respite)
☐ Home Health Providers (Private Duty Nursing, Personal Care Assistant)
☐ Individualized Service Providers (Residential Modification, Vehicle Modification, Non-Medical Transportation, Caregiver/Participant Training, Community Transition Services)
☐ LTC Facility Providers (Nursing Facility, Special Care Nursing Facility, Custodial Care, Respite Care)
☐ TBI Behavioral and Cognitive Therapy (Group and Individual)
☐ Therapy Providers (Occupational Therapy, Physical Therapy, Speech, Language and Hearing Therapy)

Incident/Alleged Incident Type:

☐ Unexpected death of a member
☐ Theft with law enforcement involvement
☐ Severe injury resulting in the need for medical treatment
☐ Medication error resulting in serious consequences
☐ Inappropriate and/or unprofessional conduct by a care provider involving the member
☐ Sexual abuse and/or suspected sexual abuse
☐ Physical abuse (including seclusion and restraints both physical and chemical)
☐ Psychological / verbal abuse
☐ Fall resulting in the need for medical treatment
☐ Medical emergency resulting in need for medical treatment
☐ Psychiatric emergency resulting in need for medical treatment
☐ Suicide attempt resulting in the need for medical attention
☐ Operational breakdown
☐ Neglect/mistreatment, caregiver (paid or unpaid)
☐ Neglect/mistreatment, self
☐ Neglect/Mistreatment, other
☐ Exploitation, financial
☐ Exploitation, theft
☐ Exploitation, destruction of property
☐ Exploitation, other
☐ Failure of member's backup Plan
☐ Elopement/wandering from home or facility
☐ Inaccessible for initial/on-site meeting
☐ Unable to contact
☐ Eviction/loss of home
☐ Facility closure, with direct impact to member's health and welfare
☐ Media involvement or the potential for media involvement
☐ Cancellation of utilities
☐ Facility closure, with direct impact to member's health and welfare
☐ Natural disaster, with direct impact to member's health and welfare
☐ Other (explain below)

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Relationship of the Alleged Perpetrator:

☐ Authorized representative
☐ Brother
☐ Daughter
☐ Daughter-in-law
☐ Father
☐ Friend or neighbor (non-caretaker)
☐ Granddaughter
☐ Grandson
☐ Guardian
☐ Mother
☐ Other relative
☐ No relationship/stranger
☐ Power of attorney
☐ Self
☐ Self-direction provider
☐ Service provider
☐ Sister
☐ Son
☐ Son-in-law
☐ Spouse/intimate partner

Description of Incident (submit additional pages if needed):

Explain the relationship of the critical incident to the member's present health status: *Is there a Risk Assessment Agreement? Was the backup plan in the member's plan of care? Does the backup plan need to change?*

If the critical incident was inflicted by another individual, identify alleged offender's name (if possible):

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Document relationship of alleged offender and member:

☐ Power of attorney ☐ Authorized representative ☐ Guardian ☐ Self-direction provider

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SECTION 3: Describe Corrective Action Taken to Prevent Future Incidents	
Actions taken immediately to mitigate risk to member: (What you did to ensure member's safety within 24 hours. Please list dates and times of attempts to contact these agencies. If faxed, please save confirmation.) ☐ **911/EMS** notified ☐ **APS** notified if incident involves an adult either suspected or actual physical, mental, sexual abuse, or exploitation. ☐ **Accrediting Agency** notified ☐ **New Jersey DOH's Divison of Developmental Disabilities (DDD)** notified ☐ **DOH Facility Hotline** notified ☐ **OOIE** notified if incident involves an adult in a nursing home involved either suspected or actual physical, mental, sexual abuse or exploitation ☐ **DCP&P/DC&P** notified if incident involves a child either suspected or actual physical, mental, sexual abuse, neglect or financial exploitation ☐ Accused worker removed from home and from providing care to UnitedHealthcare Community Plan member pending investigation ☐ New worker assigned to provide services ☐ Family member/POA notified ☐ Other – please describe: ______________________ **(Please list dates and times of attempts to contact these agencies, if faxed please save confirmation):** ______________________	
Critical incident resolved at the time of the report? ☐ Yes ☐ No	
Name of person submitting this report:	**Title and Company Name:**
Telephone number(s) where you can be reached if more information is needed:	**Email Address:**
Date this form submitted to UnitedHealthcare Community Plan in the following format [Month XX, 2016]:	**Signature:**