

HCBS CHOICES Critical Incident Report

Please select report that is being submitted.		
<input type="checkbox"/> 24 Hour Notification <input type="checkbox"/> 20 Day Follow up Report-Provider	<input type="checkbox"/> 48 Hour Written Report-Provider	
Please select the member's Managed Care Organization. (MCO)		
<input type="checkbox"/> BlueCare TennCareSelect 24 HR Verbal Report Phone: 1-888-747-8955 24 HR Written Report to: Fax: 1-855-292-3715 Email: CHOICES_CI@bcbst.com 48 Hour Written Report and 20 day follow-up report to: CHOICESQuality@bcbst.com	<input type="checkbox"/> Amerigroup 24 HR Verbal Report Phone: 1-866-840-4991 24 HR Written Report to: Fax: 1-877-423-9976 Email: TN02criticalincident@amerigroup.com 48 Hour Written and 20 day follow-up report to: TN02criticalincident@amerigroup.com	<input type="checkbox"/> UnitedHealthcare Community Plan 24 HR Verbal Report Phone: East TN: Bonnie Creel (877) 534-4270 Middle TN: Davine Brasher (615) 335-0688 West TN: Jennifer Travis (877) 714-0382 48 Hour Written Report and 20 Day Follow-up report to: Fax: 866-497-7780 Email: tn_quality_review@uhc.com
A. Member Information		
Name	Identification Number	
Social Security Number	Date of Birth	
Home Address		
CHOICES Group <input type="checkbox"/> 2 <input type="checkbox"/> 3 Region: <input type="checkbox"/> East <input type="checkbox"/> West <input type="checkbox"/> Middle	Types of Services member receiving: <input type="checkbox"/> HCBS Member <input type="checkbox"/> Consumer Direction HCBS <input type="checkbox"/> HCBS MFP Member	

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B. Reporting Incident Information			
Person Reporting Incident		Person Completing Form (if other than person reporting incident)	
Company/Title/Role		Title/Role <input type="checkbox"/> CSR <input type="checkbox"/> Care Coordinator <input type="checkbox"/> Provider Staff <input type="checkbox"/> Other MCO Staff	
Contact Phone Number		Phone Number/Extension	
C. HCBS Servicing Provider Information			
Provider Name	Provider ID	Fax Number	Phone Number
Address		Email	
HCBS Services at the time of Incident			
<input type="checkbox"/> Adult Care Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Attendant Care <input type="checkbox"/> Personal Care <input type="checkbox"/> Companion Care <input type="checkbox"/> Respite <input type="checkbox"/> PERS <input type="checkbox"/> Pest Control <input type="checkbox"/> Minor Home Modifications <input type="checkbox"/> No HCBS Provided at the time of incident			
D. Critical Incident Timelines			
Please select Time Zone (Time zones will apply to all times listed in the report)			
<input type="checkbox"/> Central Time Zone <input type="checkbox"/> Eastern Time Zone			
Date /Time Incident Occurred		<input type="checkbox"/> Undetermined	
Date/Time Provider Discovered Incident			
E. Critical Incident Type			
Select the Critical Incident Type			
<input type="checkbox"/> Unexpected Death <input type="checkbox"/> Suspected Physical or Mental Abuse <input type="checkbox"/> Theft <input type="checkbox"/> Financial Exploitation <input type="checkbox"/> Severe Injury <input type="checkbox"/> Medication Error <input type="checkbox"/> Sexual Abuse and/or Suspected Sexual Abuse <input type="checkbox"/> Abuse and Neglect and/or Suspected Abuse and Neglect <input type="checkbox"/> CLS Alleged Abuse, Exploitation/Neglect <input type="checkbox"/> CLS Serious/Suspicious Injury <input type="checkbox"/> CLS Unexpected/Unexplained Death			
F. Critical Incident Setting/Location			
HCBS Setting/Location Where Occurred			
<input type="checkbox"/> Member's Home <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Critical Adult Care Home <input type="checkbox"/> Other Community Residential <input type="checkbox"/> Errand during covered HCBS <input type="checkbox"/> Not a CHOICES HCBS Setting			

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G. Critical Incident Notifications (Please check all that apply)	
<i>Report to APS within 24 Hours if abuse, neglect or exploitation. APS Phone 888-277-8366 and APS fax 866-294-3961. Any incident that is reported to APS must be reported to the MCO as a critical incident.</i>	
<input type="checkbox"/> Reported to APS/CPS	Date/Time
<input type="checkbox"/> Reported to EMS EMS Name	Date/Time
<input type="checkbox"/> Reported to Police Police Department Name Officer Name	Date/Time
<input type="checkbox"/> Family member/POA	Date/Time
<input type="checkbox"/> Reported to Care Coordinator	Date/Time
<input type="checkbox"/> Reported to MCO	Date/Time
<input type="checkbox"/> Reported to Legal Representative	Date/Time
H. HCBS Worker Initial Information	
HCBS Worker Name	Back-up plan been initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Worker Involved in Incident <input type="checkbox"/> Yes <input type="checkbox"/> No	Lapse in Service? <input type="checkbox"/> Yes <input type="checkbox"/> No
Worker removed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Replacement Worker Implemented <input type="checkbox"/> Yes <input type="checkbox"/> No
Date and Time Worker Removed	Date and Time Replacement Worker Implemented
I. Details of Critical Incident	
If a medication theft Name of medication	Storage Type
How Prescribed? <input type="checkbox"/> Regular <input type="checkbox"/> Scheduled <input type="checkbox"/> As Needed	
Please provide a brief description of the incident: 	

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J. Immediate Actions Taken-Please attach supporting documentation such as results of drug screen, worker training/education, worker counseling, disciplinary actions and termination to the MCO.

K. 20 Day Follow-Up *The 20 day follow-up report of provider investigation, findings and conclusion of the investigation is due 20 days from the discovery date of the incident. Please include any applicable statements from the worker involved in the incident, the CHOICES member, the member's representative or their family. The 20 day follow-up report should include the details involving replacement workers or if the worker involved in the incident has been reassigned.*

Member Investigative Findings

Member Interviewed? Yes No **Date/Time**

Findings

Status of member services? Services resumed with no lapse Services resumed with Lapse (explain in Section I)
 Services on hold No longer servicing member

HCBS Worker Investigative Findings

Date/Time of Interview with Worker **Did worker pass criminal background check?**
 Yes No

Findings **Was OIG/LEIE List checked:**
Before worker was hired? Yes No
Monthly? Yes No

If medication theft, did worker pass drug screen within 24 Hours of discovery? Yes No N/A

Worker Statement Attached? **Has worker's name ever appeared on the OIG/LEIE List?**
 Yes No Yes No

Worker trained prior to incident? **Worker trained after incident?**
 Yes No Yes No

Training Date **Training Date**

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<p>Please select all training provided: <input type="checkbox"/> Critical Incidents <input type="checkbox"/> Neglect <input type="checkbox"/> Abuse <input type="checkbox"/> Exploitation <input type="checkbox"/> Safety <input type="checkbox"/> Falls <input type="checkbox"/> Other If other describe</p>	<p>Please select all training provided: <input type="checkbox"/> Critical Incidents <input type="checkbox"/> Neglect <input type="checkbox"/> Abuse <input type="checkbox"/> Exploitation <input type="checkbox"/> Safety <input type="checkbox"/> Falls <input type="checkbox"/> Other If other describe</p>
<p>List any other complaints or incidents involving worker</p>	<p>Status of Worker? <input type="checkbox"/> Administrative Leave <input type="checkbox"/> Not Removed <input type="checkbox"/> Removed <input type="checkbox"/> Terminated</p>
<p>Corrective Actions Taken</p>	
<p>Please check all that apply: <input type="checkbox"/> Counseling <input type="checkbox"/> Discipline <input type="checkbox"/> Education <input type="checkbox"/> Termination Describe Corrective Actions Implemented</p>	
<p>Investigative Findings</p>	
<p>Please include details of investigation as indicated in the Critical Incident Reporting Requirements section above</p>	
<p>Conclusion</p>	
<p>Credible Evidence Supports Allegation? <input type="checkbox"/> Yes-Describe actions in Section I <input type="checkbox"/> No-no further action needed <input type="checkbox"/> Insufficient evidence <input type="checkbox"/> Accidental in nature</p> <p>Comments</p>	