COLORADO
Department of Health Care Policy & Financing

Home Community Based-Services (HCBS) Provider Critical Incident Follow-up Form

Today's Date: _____

Provider Name: _____

Provider Agency: _____

Case Manager Name: _____

Case Management Agency Name: _____

Date of Incident: _____

Client Name: _____

Medicaid ID #: _____ Date of Birth (DOB): _____

HCBS Waiver program client is enrolled in: _____

Describe follow-up actions taken in response to incident: _____

_____

_____

_____

_____

Was an investigation of the incident conducted by the provider and/or provider agency?

☐ Yes ☐ No

If applicable, describe the investigation and findings: _____

_____

_____

_____

_____

COLORADO
Department of Health Care Policy & Financing

Are there additional actions that should be taken to resolve the incident/situation?

☐ Yes ☐ No

If yes, what additional actions need to be completed? _____

_____

_____

_____

_____

What can be learned from this incident to prevent and/or avoid future occurrences? _____

_____

_____

_____

_____

What procedural changes will be made by the provider and/or agency to prevent and/or avoid similar incidents in the future? _____

_____

_____

_____

_____