COLORADO
Department of Health Care Policy & Financing

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
- ☐ Persons with Brain Injury
- ☐ Spinal Cord Injury
- ☐ Children with Life Limiting Illness
- ☐ Children with Autism
- ☐ Community Mental Health Supports
- ☐ Elderly, Blind and Disabled

Who reported incident to Case Manager?
Name:_____

Agency and Role: _____

Primary Incident Type: (check one)

- ☐ Death
- ☐ Abuse/Neglect/Exploitation
- ☐ Serious Injury to Illness of Client
- ☐ Damage to Client's Property/Theft
- ☐ Medication Management
- ☐ Other High Risk Issues

Date of Incident:_____

Time of Incident: _____

Location of Incident: (check one)

- ☐ Alternative Care Facility (ACF)
- ☐ School
- ☐ Personal Residence
- ☐ Other_____
- ☐ Day Program
- ☐ Hospital
- ☐ In Community

Persons Involved in Incident: _____

Was anyone other than the client involved in the incident?

☐ Yes ☐ No If yes, 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:

Complete the items specific to incident type:

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
- ☐ Family Member
- ☐ Co-Habitant
- ☐ Other _____

Did Abuse / Neglect / Exploitation Result in Hospitalization?

☐ Yes ☐ No

If yes, where was client hospitalized?

Serious Injury / Illness of Client

Serious Injury / Illness Type: (check one)

- ☐ Laceration requiring sutures/staples
- ☐ Fracture
- ☐ Dislocation
- ☐ Loss of Limb
- ☐ Other _____
- ☐ Serious Burn
- ☐ Skin Wound due to poor care
- ☐ Suicide Attempt
- ☐ Brain Injury

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, 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 Medication
- ☐ variance) Wrong Route of Administration
- ☐ Non-Compliance
- ☐ Wrong Dose
- ☐ Wrong Time (>1hr.
- ☐ Medication Refused
- ☐ Other _____

Reason for Event: (check one)

- ☐ Administration Error
- ☐ Forgotten
- ☐ Prescription Unfilled
- ☐ Other _____
- ☐ Supply Exhausted
- ☐ Refusal
- ☐ Incorrect Chart Entry

Administered by/Set-up by: (check one)

- ☐ Consumer
- ☐ Provider Set-up Only
- ☐ Family Member
- ☐ Provider
- ☐ Provider Administration Only
- ☐ Other _____

Did the Medication Error Result in Hospitalization?

☐ Yes ☐ No

If yes, where was client hospitalized?

Other High-Risk Issues

Risk Issue Type:

- ☐ Lost/Missing Person
- ☐ Loss of Home/Eviction
- ☐ Client Fraud
- ☐ Criminal Justice Involvement
- ☐ Victim of Crime
- ☐ Other _____
- ☐ Suicidal Ideation/Attempt
- ☐ Substance Abuse
- ☐ Provider Fraud
- ☐ Critical Service Interruption
- ☐ Abusive/Violent Behavior by Client

Why is this issue of particular risk to this person?

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:
