



Critical Incident Form

Definition: A Critical Incident is an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a client that could have, or has had, a negative impact on the mental and/or physical well-being of a client in the short or long term. A critical incident includes accidents, suspicion of abuse, neglect, or exploitation, and criminal activity.

| Member Information | | |
|---------------------------|----------------|-------|
| Last Name: | First Name: | M.I.: |
| Medicaid ID#: | Date of Birth: | |
| Mailing Address: | | |
| HCBS Waiver Program: | | |

| Critical Incident Reporting | |
|------------------------------------|--|
| Date of Incident: | Time of Incident: |
| Case Manager Notification Date: | Case Manager Incident Notification Time: |
| Entry Date: | Entry Time: |
| Case Manager Name: | |
| Case Manager Agency Name: | |
| Case Manager Phone Number: | |
| Case Manager Email Address: | |
| Entered By: | |
| Phone Number of Contact Person: | |
| Email Address of Contact Person: | |

| Reporter Information |
|--|
| Name of Person Reporting Incident to CMA: |
| Did the member report this incident? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name of Provider Agency or PASA who Reported incident to Case Manager: |
| Is the Provider Agency reporting the incident an Alternative Care Facility (ACF)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was a Provider involved in the Critical Incident? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Provider Type: |
| Name of Provider: |

| Reporter Information | |
|--|--|
| Was anyone other than the client involved in the incident? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has this critical incident been substantiated? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was a Referral Made to APS/CPS? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was Law Enforcement involved in this CIR? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| Incident Info | |
|--|--|
| Incident Type: Other High Risk Issues | |
| Location of Incident: | |
| Location Address: | |
| If applicable Facility Name: | |
| Did this incident involve Restrictive Interventions? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Type of Intervention: | |
| Explanation of Intervention: | |
| Was this incident referred to the Human Rights Committee (HRC) for review? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Was the use of Restrictive Intervention used Appropriately? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Did the incident result in an admission and/or treatment in the Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Did the Incident Result in Hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If applicable - Type of Hospital: | |
| If applicable - Name of Hospital: | |
| Did this incident result in a Skilled Nursing Facility Rehab Stay? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Did this incident result in Nursing Facility placement? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Did this incident result in a change and/or additional waiver services? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Explanation of additional waiver services: | |

| |
|--|
| Incident Info |
| Did this incident result in Reverse Deinstitutionalization (RDI)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did the incident require an occurrence report to CDPHE? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Could this critical incident have been prevented? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| What could be done to prevent this type of incident in the future? |
| What was the client's health status prior to this Critical Incident? |

Other High Risk Issues:
Reporting incidents to HCPF does not relieve the facility or provider from reporting requirements of other regulatory or law enforcement agencies.

| |
|---|
| Incident Type |
| What is the Root Cause of the Critical Incident? |
| Incident Type: Other High Risk Issues |
| Description of Incident: |
| Risk Issue Type: |
| If Critical Service Interruption, answer the question below: Critical Services are those services that if not delivered in accordance with the client's service plan would result in a critical incident, such as death, hospitalization, reinstitutionalization or an emergency room visit. The critical services should be identified in the emergency backup plan and the contingency plan section in client's service plan in the BUS. |
| Critical Service Interruption Type: |
| Name of Direct Service Provider Agency: |
| Type of Critical Service: |

Incident Type

Why is this issue of particular risk to this person?: