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

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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:**

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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?**

- [ ] Laceration requiring sutures/staples
- [ ] Fracture
- [ ] Dislocation
- [ ] Loss of Limb
- [ ] Serious Burn
- [ ] Skin Wound due to poor care
- [ ] Suicide Attempt
- [ ] Brain Injury
- [ ] Other ________________________
**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
- Deliberate Diversion of Medication
- Theft of Property
- Other ________________

**Medication Management**

**Name of Medication:** __________________________

**Medication Related Event Type:** (check one)

- Medication Omission
- Wrong Medication
- Wrong Time (>1hr. variance) Wrong Route of Administration
- Non-Compliance
- Wrong Dose
- Medication Refused
- Other ________________

**Reason for Event:** (check one)

- Administration Error
- Forgotten
- Prescription Unfilled
- Supply Exhausted
- Refusal
- Incorrect Chart Entry
- Other ________________
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 ☐ Suicidal Ideation/Attempt
☐ Loss of Home/Eviction ☐ Substance Abuse
☐ Client Fraud ☐ Provider Fraud
☐ Criminal Justice Involvement ☐ Critical Service Interruption
☐ Victim of Crime ☐ Abusive/Violent Behavior by Client
☐ Other __________________

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: ____________________________

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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:

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