

## CHPW INCIDENT REPORT FORM

<b>Date Reported to CHPW:</b> Click here to enter text.	<b>Date of Incident</b> Click here to enter text.	<b>Time of Incident</b> Click here. (24 hour)	<b>Location of Incident:</b> Click here to enter text.
<b>Reporting Site:</b> Choose an item.	<b>Name of Reporter:</b> Click here to enter text.	<b>Phone/Email:</b> Click here to enter text./ Click here to enter text.	
<b>Provider Agency:</b> Click here to enter text.			
<b>Brief Description of the Incident:</b> Click here to enter text.			
<input type="checkbox"/> UNSUBSTANTIATED  <input type="checkbox"/> SUBSTANTIATED		<input type="checkbox"/> UNDER INVESTIGATION/UNDETERMINED	
<input type="checkbox"/> POTENTIAL FOR MEDIA COVERAGE?		<input type="checkbox"/> PROPERTY DAMAGE?	
<b>TYPE OF INCIDENT</b> <i>Instructions: Please Select on the appropriate category from the list below;</i> <i>*Category Level 1 Critical Incident must be reported individually to HCA within 24 hours and will require follow up report within 45 calendar days.</i> <i>**Non-Category Level 1 Critical Incident is not required to be reported individually to HCA but will be included in the semi-annually population based reporting.</i>			
<input type="checkbox"/> The unexpected death of a client that occurs in facility licensed by the state of Washington to provide publicly funded behavioral health services.* <input type="checkbox"/> A major injury or major trauma that has the potential to cause prolonged disability or death of a client that occurs in a facility licensed by the state of Washington to provide publicly funded behavioral health services* <input type="checkbox"/> Attempted or Completed Suicide** <input type="checkbox"/> Abuse, neglect, and exploitation of an Enrollee <ul style="list-style-type: none"> <li>• Not to include child abuse</li> </ul> <input type="checkbox"/> Any allegation of financial exploitation of an Enrollee** <input type="checkbox"/> A credible threat to Enrollee safety**		<b>Violent acts allegedly committed by an Enrollee include:</b> <input type="checkbox"/> Drive by shooting* <input type="checkbox"/> Vehicular homicide* <input type="checkbox"/> Robbery* <input type="checkbox"/> Homicide or attempted homicide by abuse* <input type="checkbox"/> Kidnapping* <input type="checkbox"/> Extortion* <input type="checkbox"/> Rape, sexual assault or indecent liberties* <input type="checkbox"/> Assault resulting in a serious bodily harm * <input type="checkbox"/> Unauthorized leave of mentally ill offender or a sexual or violent offender from a mental health facility, secure community transition facilities (i.e. Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions.*	
<b>Patient (1) Information</b>		<b>Patient (2) Information</b>	
<b>Patient Identifier:</b> Click here to enter text.	<b>Name: Last, First</b> Click here to enter text.	<b>Patient Identifier:</b> Click here to enter text.	<b>Name: Last, First</b> Click here to enter text.
<b>Date of Birth:</b> Click here to enter text.	<b>PI:</b> Click here. <b>JIVA:</b> Click here.	<b>Date of Birth:</b> Click here to enter text.	<b>PI:</b> Click here. <b>JIVA:</b> Click here.
<b>Staff (1) Information</b>		<b>Staff (2) Information</b>	
<b>Name: Last, First</b> Click here to enter text.		<b>Name: Last, First</b> Click here to enter text.	
<b>Visitor/Other Information</b>		<b>Staff (3) Information</b>	
<b>Name: Last, First</b> Click here to enter text.		<b>Name: Last, First</b> Click here to enter text.	
<b>Relationship:</b> Click here to enter text.		<b>Other Pertinent Information Related to the Visitor:</b> Click here to enter text.	
<b>OTHER AGENCY/FACILITIES NOTIFIED/INVOLVED</b>			

<input type="checkbox"/> Law Enforcement Notified <input type="checkbox"/> Family Notified <input type="checkbox"/> APS Notified <input type="checkbox"/> CPS Notified	<input type="checkbox"/> DSHS Communications <input type="checkbox"/> Medicaid Control Faud <input type="checkbox"/> Department of Health <input type="checkbox"/> DSHS Notified	<input type="checkbox"/> Media Has Contacted Agency <input type="checkbox"/> None <input type="checkbox"/> Other: <a href="#">Click here.</a> Date of Referral: <a href="#">Click here.</a>
<b>FOLLOW-UP/CORRECTIVE ACTION INFORMATION</b>		<input type="checkbox"/> <b>THIS INCIDENT DOES NOT REQUIRE FOLLOW-UP</b>
<b>Follow-up Date:</b> <a href="#">Click here to enter text.</a>	<b>A summary of any debriefings and whether the Enrollee is in custody (jail), in the hospital or in the community:</b> <a href="#">Click here to enter text.</a>	
<b>Follow-up Date:</b> <a href="#">Click here to enter text.</a>	<b>Actions Taken: Whether the Enrollee is receiving services and include types of services provided;</b> <a href="#">Click here to enter text.</a>	
<b>Follow-up Date:</b> <a href="#">Click here to enter text.</a>	<b>Actions Taken: If the Enrollee cannot be located or contacted, the steps by the Contractor to locate the Enrollee using available local resources;</b> <a href="#">Click here to enter text.</a>	
<b>Corrective Action Plan?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	<b>Describe CAP Briefly:</b> <a href="#">Click here to enter text.</a>	
<b>Case Closed?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Date Close:</b> <a href="#">Click here to enter text.</a>	<b>In the case of death of an Enrollee, verification from official sources that includes the date, name and title of the sources:</b> <a href="#">Click here to enter text.</a>

You must notify CHPW within 24 business hours of learning of the incident. In the event that an incident occurs on a weekend or holiday, report the incident on the next business day.

**Category Level 1 incidents:** Will require a follow up report to HCA within 45 calendar days from the date initially reported to HCA. Depending on the type of healthcare services offered or rendered to member, the follow up report may have to be completed by the reporting provider/staff or by CHPW or by coordination from both parties.

Please submit this form to Community Health Plan of Washington at:

E-Mail: [Critical.Incidents@chpw.org](mailto:Critical.Incidents@chpw.org)

If you don't have access to email, you may fax to: 206-652-7056