



Patient/Client Information			
Provider One #		Date of Birth	
Last Name		First Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Not Specified	Race	
County of Residence		Date of Report	
County of Incident		Other Information	
Date of Last Visit		Date of Last Med Mgmt	
Incident Information			
Date of Incident		Time of Incident (if known)	
Facility		Facility Contact Info	
Level of Care	<input type="checkbox"/> Inpatient <input type="checkbox"/> Residential Tx <input type="checkbox"/> Crisis Stabilization <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient <input type="checkbox"/> FQHC <input type="checkbox"/> Independent Provider <input type="checkbox"/> Other (please specify)		
Location of Incident (if known)			
Type of Incident (Required by ASO/MCOs)	Incidents that occurred to a member/client while they were within a contracted behavioral health facility, FQHC or by an independent provider		
	<input type="checkbox"/>	Abuse/Neglect/Sexual or Financial Exploitation	<input type="checkbox"/> Death
	<input type="checkbox"/>	Severely adverse medical outcome or death occurring within 72 hours of transfer from a contracted behavioral facility to a medical treatment facility (new requirement for January 2021) (Required by MCO ONLY)	
	Incidents that occurred by a member/client (allegedly committed the following) – member must have a current behavioral health diagnosis or history of behavioral health treatment in the previous 365 days		
	<input type="checkbox"/>	Homicide or Attempted Homicide	<input type="checkbox"/> Arson
	<input type="checkbox"/>	Assault or action resulting in serious bodily harm which has the potential to cause disability or death	<input type="checkbox"/> Kidnapping
	<input type="checkbox"/>	Sexual Assault	
	Other Incidents		
	<input type="checkbox"/>	Unauthorized leave from a behavioral health facility during an involuntary detention	<input type="checkbox"/> Any event that has or will attract media attention – include link to media source in description
	<input type="checkbox"/>	Incident posing a credible threat to the member's safety	<input type="checkbox"/> Suicide Attempt/Completed
Other Incidents (Required by ASO or another Entity/Provider)	<input type="checkbox"/> Elopement (resulting in patient death or serious injury)	<input type="checkbox"/> Bomb threat	<input type="checkbox"/> Sexual behavior, abuse, or assault on a member or staff within or on the grounds of a healthcare setting
	<input type="checkbox"/> Fall (resulting in death or serious injury while on the grounds of a healthcare setting)	<input type="checkbox"/> Any serious injury in a treatment setting resulting in urgent/emergent interventions	<input type="checkbox"/> Self-inflicted harm (resulting in death or serious injury while in treatment)
	<input type="checkbox"/> Accident (resulting in death or serious injury within a healthcare setting)	<input type="checkbox"/> Medications/Treatment error (resulting in death or serious injury)	<input type="checkbox"/> Unscheduled event that results in the evacuation of a program/facility
	<input type="checkbox"/> Unplanned transfers to a medical unit	<input type="checkbox"/> Other occurrences, not listed, representing actual serious harm to a member (provide explanation)	



	<input type="checkbox"/> Death or serious injury of a staff or public citizen(s) at a licensed site <input type="checkbox"/> Alleged abuse or neglect of a client of a serious or emergency nature, by a workforce member or another individual in services <input type="checkbox"/> A natural disaster or outbreak of a communicable disease that presents a substantial threat to licensed facility operation or client safety	<input type="checkbox"/> Credible threat to a staff member that occurs at a licensed facility resulting in a report to LE, a restraining/protection order, or a workplace safety plan <input type="checkbox"/> Theft or loss of client data in any form <input type="checkbox"/> Breach or loss of client data considered reportable under HITECH that would allow for unauthorized use of client PHI	<input type="checkbox"/> Any incident reported to the Medicaid fraud unit <input type="checkbox"/> A life event that requires an evacuation or that is a substantial disruption to the facility
Description of Incident			
Other Individuals Involved – complete this section if you know of other individuals involved in the incident			
Last Name		First Name	
Relationship		How were other individuals involved?	
Other Agency/Facilities Notified – complete this section if you know of any agencies/facilities notified (i.e. APS/CPS/local police)			
Date		Type of Agency or Facility Notified	
Reporting Information			
Name/Role of person reporting incident		Provider Group/CCO/ASO/Other	
Date Submitted		Phone number of person reporting	
Email address of person reporting			
Other comments or information regarding incident			
Steps taken to ensure safety of member/client; current disposition of member/client: (outreach attempts, safety plans, wellness check, hospitalization, appointments, referrals)			
Steps taken to ensure safety of facility, employees, records, etc. and business continuity			