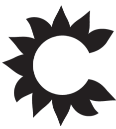

COMMUNITY HEALTH PLAN of Washington™

CRITICAL INCIDENT REPORT FORM

Date Reported to CHPW:	Date of Incident	Time of Incident *(24 hour)*	Location of Incident:

Reporting Site: Provider Agency:	Name of Reporter:	Phone/Email: /

Brief Description of the Incident:

☐ UNSUBSTANTIATED ☐ SUBSTANTIATED	☐ UNDER INVESTIGATION/UNDETERMINED

☐ POTENTIAL FOR MEDIA COVERAGE?	☐ PROPERTY DAMAGE?

TYPE OF INCIDENT

Instructions: Please Select on the appropriate category from the list below;

**Category Level 1 Critical Incident must be reported individually to HCA within 24 hours and will require follow up report within 45 calendar days.*

***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.*

- ☐Attempted or Completed Suicide**
- ☐Poisoning/overdoses unintentional or intention unknown**
- ☐Incidents posing a credible threat to Enrollee safety**
- ☐Abuse, neglect, or sexual/financial exploitation to an Enrollee, and occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider*
- ☐Death to an Enrollee, and occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider*

Violent acts allegedly committed by an Enrollee, with a behavioral health diagnosis; or history of behavioral health treatment within the previous 365 days. Acts to include:

- ☐Arson*
- ☐Kidnapping*
- ☐Sexual assault*
- ☐Homicide or attempted homicide*
- ☐Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death*

- ☐Unauthorized leave from a behavioral health facility during an involuntary detention*
- ☐Any event involving an Enrollee that has attracted or is likely to attract media coverage. (Contractor shall include the link to the source of the media, as available) *

Patient (1) Information		Patient (2) Information	
Patient Identifier:	Name: Last, First	Patient Identifier:	Name: Last, First
Date of Birth:	PI: JIVA:	Date of Birth:	PI: JIVA:

Staff (1) Information	Staff (2) Information	Staff (3) Information
Name: Last, First	Name: Last, First	Name: Last, First

<table>
<tr><th colspan="3">Visitor/Other Information</th></tr>
<tr><td>Name: Last, First</td><td>Relationship:</td><td>Other Pertinent Information Related to the Visitor:</td></tr>
<tr><th colspan="3">OTHER AGENCY/FACILITIES NOTIFIED/INVOLVED</th></tr>
<tr><td>☐ Law Enforcement Notified
☐ Family Notified
☐ APS Notified
☐ CPS Notified</td><td>☐ DSHS Communications
☐ Medicaid Control Fraud
☐ Department of Health
☐ DSHS Notified</td><td>☐ Media Has Contacted Agency
☐ None
☐ Other :
Date of Referral:</td></tr>
</table>

<table>
<tr><th>FOLLOW-UP/CORRECTIVE ACTION INFORMATION</th><th colspan="2">☐ THIS INCIDENT DOES NOT REQUIRE FOLLOW-UP</th></tr>
<tr><td>Follow-up Date:</td><td colspan="2">A summary of any debriefings and whether the Enrollee is in custody (jail), in the hospital or in the community:</td></tr>
<tr><td>Follow-up Date:</td><td colspan="2">Actions Taken: Whether the Enrollee is receiving services and include types of services provided;</td></tr>
<tr><td>Follow-up Date:</td><td colspan="2">Actions Taken: If the Enrollee cannot be located or contacted, the steps by the Contractor to locate the Enrollee using available local resources;</td></tr>
<tr><td>Corrective Action Plan?
☐ YES ☐ NO ☐ N/A</td><td colspan="2">Describe CAP Briefly:</td></tr>
<tr><td>Case Closed?
☐ YES ☐ NO</td><td>Date Close:</td><td>In the case of death of an Enrollee, verification from official sources that includes the date, name and title of the sources:</td></tr>
</table>

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