HCBS CHOICES Critical Incident Report

Please select report that is being submitted.	
☐ **24 Hour Notification** ☐ **20 Day Follow up Report-Provider**	☐**48 Hour Written Report-Provider**

Please select the member's Managed Care Organization. (MCO)		
☐ **BlueCare TennCare*Select*** **24 HR Verbal Report Phone:** 1-888-747-8955 **24 HR Written Report to**: **Fax**: 1-855-292-3715 **Email**: CHOICES_CI@bcbst.com **48 Hour Written Report and 20 day follow-up report to:** CHOICESQuality@bcbst.com	☐ **Amerigroup Community Care** **24 HR Verbal Report Phone:** 1-866-840-4991 **24 HR Written Report to:** **Fax:** 1-877-423-9976 **Email**: TN02criticalincident@amerigroup.com **48 Hour Written and 20 day follow-up report to:** TN02criticalincident@amerigroup.com	☐**UnitedHealthcare Community Plan** **24 HR Verbal Report Phone:** **East TN:** Bonnie Creel (877) 534-4270 **Middle TN**: Davine Brasher (615) 335-0688 **West TN:** Jennifer Travis (877) 714-0382 **48 Hour Written Report and 20 Day Follow-up report to:** **Fax:** 866-497-7780 **Email:** tn_quality_review@uhc.com

A. Member Information	
Name Click here to enter text.	**Identification Number** Click here to enter text.
Social Security Number Click here to enter text.	**Date of Birth** Click here to enter a date.
Home Address Click here to enter text.	
CHOICES Group ☐ 2 ☐ 3 **Region:** ☐ East ☐ West ☐ Middle	**Types of Services member receiving:** ☐ HCBS Member ☐ Consumer Direction HCBS ☐ HCBS MFP Member
B. Reporting Incident Information	

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Person Reporting Incident Click here to enter text.	**Person Completing Form (if other than person reporting incident)** Click here to enter text.
Company/Title/Role Click here to enter text.	**Title/Role** ☐ CSR ☐ Care Coordinator ☐ Provider Staff ☐ Other MCO Staff
Contact Phone Number Click here to enter text.	**Phone Number/Extension** Click here to enter text.

C. HCBS Servicing Provider Information

Provider Name	**Provider ID**	**Fax Number**	**Phone Number**
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Address Click here to enter text.	**Email** Click here to enter text.

HCBS Services at the time of Incident

☐Adult Care Home ☐Assisted Living Facility ☐ Attendant Care ☐ Personal Care
☐Companion Care ☐Respite ☐PERS ☐ Pest Control
☐ Minor Home Modifications ☐No HCBS Provided at the time of incident

D. Critical Incident Timelines

Please select Time Zone (Time zones will apply to all times listed in the report)

☐ **Central Time Zone** ☐**Eastern Time Zone**

Date /Time Incident Occurred Click here to enter text. ☐ **Undetermined**

Date/Time Provider Discovered Incident Click here to enter text.

E. Critical Incident Type

Select the Critical Incident Type

☐ Unexpected Death ☐Suspected Physical or Mental Abuse
☐ Theft ☐ Financial Exploitation ☐ Severe Injury ☐Medication Error
☐ Sexual Abuse and/or Suspected Sexual Abuse ☐ Abuse and Neglect and/or Suspected Abuse and Neglect
☐ CLS Alleged Abuse, Exploitation/Neglect ☐ CLS Serious/Suspicious Injury
☐ CLS Unexpected/Unexplained Death

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F. Critical Incident Setting/Location

HCBS Setting/Location Where Occurred

☐ Member's Home ☐ Adult Day Care ☐Assisted Living Facility ☐ Critical Adult Care Home
☐ Other Community Residential ☐ Errand during covered HCBS ☐ Not a CHOICES HCBS Setting

G. Critical Incident Notifications (Please check all that apply)

Report to APS within 24 Hours if abuse, neglect or exploitation. APS Phone 888-277-8366 and APS fax 866-294-3961. Any incident that is reported to APS must be reported to the MCO as a critical incident.

☐ **Reported to APS/CPS**	**Date/Time** Click here to enter text.
☐ **Reported to EMS** Click here to enter text. **EMS Name** Click here to enter text.	**Date/Time** Click here to enter text.
☐ **Reported to Police** **Police Department Name** Click here to enter text. **Officer Name** Click here to enter text.	**Date/Time** Click here to enter text.
☐ **Family member/POA**	**Date/Time** Click here to enter text.
☐ **Reported to Care Coordinator**	**Date/Time** Click here to enter text.
☐ **Reported to MCO**	**Date/Time** Click here to enter text.
☐ **Reported to Legal Representative**	**Date/Time** Click here to enter text.

H. HCBS Worker Initial Information

HCBS Worker Name Click here to enter text.	**Back-up plan been initiated?** ☐Yes ☐No
Worker Involved in Incident ☐ Yes ☐ No	**Lapse in Service?** ☐Yes ☐No
Worker removed? ☐ Yes ☐No	**Replacement Worker Implemented** ☐ Yes ☐No
Date and Time Worker Removed Click here to enter text.	**Date and Time Replacement Worker Implemented** Click here to enter text.

I. Details of Critical Incident

If a medication theft Name of medication Click here to enter text. **Storage Type** Click here to enter text.

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How Prescribed? ☐ **Regular Scheduled** ☐ **As Needed**	
Please provide a brief description of the incident: Click here to enter text.	
J. Immediate Actions Taken-Please attach supporting documentation such as results of drug screen, worker training/education, worker counseling, disciplinary actions and termination to the MCO.	
Click here to enter text.	
K. 20 Day Follow-Up *The 20 day follow-up report of provider investigation, findings and conclusion of the investigation is due 20 days from the discovery date of the incident. Please include any applicable statements from the worker involved in the incident, the CHOICES member, the member's representative or their family. The 20 day follow-up report should include the details involving replacement workers or if the worker involved in the incident has been reassigned.*	
Member Investigative Findings	
Member Interviewed? ☐ Yes ☐ No	**Date/Time** Click here to enter text.
Findings Click here to enter text.	
Status of member services? ☐ Services resumed with no lapse ☐ Services resumed with Lapse (explain in Section I) ☐ Services on hold ☐ No longer servicing member	
HCBS Worker Investigative Findings	
Date/Time of Interview with Worker Click here to enter text.	**Did worker pass criminal background check?** ☐ Yes ☐ No
Findings Click here to enter text. **If medication theft, did worker pass drug screen within 24 Hours of discovery?** ☐ Yes ☐ No ☐ N/A	**Was OIG/LEIE List checked:** **Before worker was hired?** ☐ Yes ☐ No **Monthly?** ☐ Yes ☐ No
Worker Statement Attached? ☐ Yes ☐ No	**Has worker's name ever appeared on the OIG/LEIE List?** ☐ Yes ☐ No
Worker trained prior to incident? ☐ Yes ☐ No **Training Date** Click here to enter a date. **Please select all training provided:** ☐**Critical Incidents** ☐**Neglect** ☐**Abuse** ☐**Exploitation** ☐**Safety** ☐ **Falls** ☐ **Other**	**Worker trained after incident?** ☐ Yes ☐ No **Training Date** Click here to enter a date. **Please select all training provided:** ☐**Critical Incidents** ☐**Neglect** ☐**Abuse** ☐**Exploitation** ☐**Safety** ☐ **Falls** ☐ **Other**

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If other describe Click here to enter text.	**If other describe** Click here to enter text.
List any other complaints or incidents involving worker Click here to enter text.	**Status of Worker**? ☐ Administrative Leave ☐ Not Removed ☐ Removed ☐Terminated
Corrective Actions Taken	
Please check all that apply: ☐ Counseling ☐ Discipline ☐ Education ☐ Termination Describe Corrective Actions Implemented Click here to enter text.	
Investigative Findings	
Please include details of investigation as indicated in the Critical Incident Reporting Requirements section above Click here to enter text.	
Conclusion	
Credible Evidence Supports Allegation? ☐ Yes-Describe actions in Section I ☐No-no further action needed ☐Insufficient evidence ☐ Accidental in nature Comments Click here to enter text.	