HCBS CHOICES Critical Incident Report

Please select report that is being submitted.	
☐ **24 Hour Notification**	☐ **48 Hour Written Report-Provider**
☐ **20 Day Follow up 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:** 1-833-339-3319 **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:** 1-844-811-0777 **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	**Identification Number**
Social Security Number	**Date of Birth**
Home Address	
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	
Person Reporting Incident	**Person Completing Form (if other than person reporting incident)**

HCBS CHOICES Critical Incident Report

Company/Title/Role	**Title/Role** ☐ CSR ☐ Care Coordinator ☐ Provider Staff ☐ Other MCO Staff
Contact Phone Number	**Phone Number/Extension**

C. HCBS Servicing Provider Information

Provider Name	**Provider ID**	**Fax Number**	**Phone Number**

Address	**Email**

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 ☐ **Undetermined**

Date/Time Provider Discovered Incident

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

F. Critical Incident Setting/Location

HCBS CHOICES Critical Incident Report

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**
☐ **Reported to EMS** **EMS Name**	**Date/Time**
☐ **Reported to Police** **Police Department Name** **Officer Name**	**Date/Time**
☐ **Family member/POA**	**Date/Time**
☐ **Reported to Care Coordinator**	**Date/Time**
☐ **Reported to MCO**	**Date/Time**
☐ **Reported to Legal Representative**	**Date/Time**
H. HCBS Worker Initial Information	
HCBS Worker Name	**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	**Date and Time Replacement Worker Implemented**
I. Details of Critical Incident	
If a medication theft Name of medication	**Storage Type**
How Prescribed? ☐ **Regular Scheduled** ■ **As Needed**	

HCBS CHOICES Critical Incident Report

Please provide a brief description of the incident:	
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.	
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**
Findings	
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	**Did worker pass criminal background check?** ☐ Yes ☐ No
Findings **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** **Please select all training provided:** ☐**Critical Incidents** ☐**Neglect** ☐**Abuse** ☐**Exploitation** ☐**Safety** ☐ **Falls** ☐ **Other** **If other describe**	**Worker trained after incident?** ☐ Yes ☐ No **Training Date** **Please select all training provided:** ☐**Critical Incidents** ☐**Neglect** ☐**Abuse** ☐**Exploitation** ☐**Safety** ☐ **Falls** ☐ **Other** **If other describe**

HCBS CHOICES Critical Incident Report

List any other complaints or incidents involving worker	**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	
Investigative Findings	
Please include details of investigation as indicated in the Critical Incident Reporting Requirements section above	
Conclusion	
Credible Evidence Supports Allegation? ☐ Yes-Describe actions in Section I ☐No-no further action needed ☐Insufficient evidence ☐ Accidental in nature Comments	