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FCS Critical Incident or Death Notification Form

Submitter information	
Name:	Phone number:
Title:	Email:
Enrollee information	
Name:	FCS TPA ID:
DOB:	Provider One ID # (Ends in WA. Leave blank if unknown.):
Critical incident information	
Date and time reported:	Date and time of incident or death:
Type of incident:	Location:
Brief description of incident	
Comments (including follow-up actions taken)	

To be completed by submitter:

☐ The information provided is complete and true.

☐ I expect to add additional information regarding actions taken in response to this incident.

☐ I am reporting the death of an enrollee that is not a critical incident.

Please note: This form is intended to inform *only* Foundational Community Supports (FCS) of a critical incident or death.