

# Critical Incident Form

(ABI, ABI-LT, HCB, MPW, SCL, SGF)

Confidentiality Notice: This document contains confidential and privileged information.  
Any unauthorized review, use, disclosure or distribution is prohibited.

Funding Source:	<input type="checkbox"/> ABI	<input type="checkbox"/> ABI-LTC	<input type="checkbox"/> HCB	<input type="checkbox"/> MPW	<input type="checkbox"/> SCL	<input type="checkbox"/> SGF
Participant Directed Services?: <input type="checkbox"/>						

Individual's Last Name: _____ Individual's First Name: _____ Social Security Number: _____ Date of Birth: _____ Medicaid Number: _____	Reporting Agency: _____ Reporter's Last Name: _____ Reporter's First Name: _____ Reporter's Phone: _____ Reporter's Title: _____
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**Detail and Notification of Critical Incident**

\*IMMEDIATELY NOTIFY DCBS, Case Manager, guardian and regulating agency if Suspected Abuse, Neglect or Exploitation are selected.  
Otherwise, notify Case Manager, guardian and regulating agency within (8) hours of Critical Incident.

<input type="checkbox"/> *Suspected Abuse	<input type="checkbox"/> Missing Person	Critical Incident:    Date: _____    Time: _____  Discovery:            Date: _____    Time: _____ Location Phone Number (Include Area Code): _____
<input type="checkbox"/> *Suspected Neglect	<input type="checkbox"/> Serious Med Error	
<input type="checkbox"/> *Suspected Exploitation	<input type="checkbox"/> Death	
<input type="checkbox"/> Homicidal Ideation	<input type="checkbox"/> Suicidal Ideation	
<input type="checkbox"/> Other (Describe): _____	<input type="checkbox"/> Loss of Limb	

Name of Location of Incident: \_\_\_\_\_

**Regulating Agency:**

Notification: \_\_\_\_\_

Address and County of Critical Incident: \_\_\_\_\_

Date: \_\_\_\_\_    Time: \_\_\_\_\_

**Case Manager Notification:**

Date: \_\_\_\_\_    Time: \_\_\_\_\_

Hotline ID #: \_\_\_\_\_

CM Agency Name: \_\_\_\_\_

Accepted for Investigation:  
 Yes     No     Unknown

CM Phone #: \_\_\_\_\_

Date: \_\_\_\_\_    Time: \_\_\_\_\_

CM Name: \_\_\_\_\_

**Guardian Notification:**

Date: \_\_\_\_\_    Time: \_\_\_\_\_

Name: \_\_\_\_\_

**Briefly describe what happened: (Use the first and last name(s) of any staff involved)**

# Critical Incident Form Follow-Up

(ABI, ABI-LT, HCB, MPW, SCL, SGF)

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Individual's Name: \_\_\_\_\_ Incident Date: \_\_\_\_\_

**1) What is the person's current status? (Choose one)** \*Use space below to provide detail

- |  |  |
|--|--|
| <input type="checkbox"/> Stable with no serious changes noted.   | <input type="checkbox"/> Seen by professional and admitted to facility.(Specify location & date below) |
| <input type="checkbox"/> Seen by professional and returned home. | <input type="checkbox"/> Other, Briefly describe:  |

**2) Why did the critical incident occur? (Choose one)** \*Use space below to provide detail

- |  |
|--|
| <input type="checkbox"/> Failure to follow Crisis Support Plan and/or Behavior Support Plan. |
| <input type="checkbox"/> Unable to determine.  |
| <input type="checkbox"/> Other, Briefly describe:  |

**3) Could this critical incident have been prevented?**  Yes  No \*Use space below to provide detail

If yes, then how could the critical incident have been prevented? (Choose one)

- |  |   |
|--|---|
| <input type="checkbox"/> Track/monitor medical treatment. (ER, doctor, hospital, etc.) | <input type="checkbox"/> Track/monitor precious critical incidents. |
| <input type="checkbox"/> Ensure timely implementation of current Crisis Support Plan.  | <input type="checkbox"/> Other, Briefly describe:                   |

**4) Were staff training needs identified?**  Yes  No

If yes, then identify: (Choose all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Person-specific training. For example, dining plan, positioning, etc. | <input type="checkbox"/> Crisis Prevention.         |
| <input type="checkbox"/> Abuse/Neglect/Exploitation prevention and reporting.                  | <input type="checkbox"/> Medication administration. |
| <input type="checkbox"/> Failure to follow agency Policies and Procedures.                     |   |

**5) Identify needed changes to prevent similar critical incidents. (Choose all that apply)** \*Use space below to provide detail

- |   |  |
|---|--|
| <input type="checkbox"/> Watch more for advance signs of and triggers for the incident. | <input type="checkbox"/> Team Meeting.                             |
| <input type="checkbox"/> Improve communication within the agency and between agencies.  | <input type="checkbox"/> Agency processes/procedures improvements. |
| <input type="checkbox"/> Other, Briefly describe:                                       |  |

**Submitted By:**

Printed Name/Title:		Signature:		Date:	
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**Additional Signatures:**

Printed Name/Title:		Signature:		Date:	
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Printed Name/Title:		Signature:		Date:	
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