Kentucky 1915 (c) Home and Community Based Services (HCBS) Waiver Programs - Incident Reporting Form

- For critical incidents, submit this form to the appropriate regulating agency (DMS, DAIL, or DBHDID). *Timeframe for reporting:* Same day if the critical incident is witnessed or discovered during regular business hours (8 am-4:30 pm Eastern Time Monday-Friday, excluding state holidays) OR next business day if the critical incident is witnessed or discovered outside of regular business hours.
- For non-critical incidents, complete this form within 24 hours of witnessing or discovering (excludes state holidays) and track and store at the location of the waiver provider who is completing this form. This form should not be submitted to the regulating agency; however, this form should be available for audit/review upon request.

Program: ☐ **ABI** ☐ **ABI-LTC** ☐ **HCB** ☐ **MIIW** ☐ **MPW** ☐ **SCL**
Participant Directed Services? ☐ **Yes** ☐ **No**

WAIVER PARTICIPANT INFORMATION

Waiver Participant's First Name: _____ Waiver Participant's Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Social Security #: _____

Medicaid Number: _____

Gender: ☐ Male ☐ Female ☐ Unspecified

Diagnosis/Illnesses (if known): _____

Race or Ethnicity:

☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Pacific Islander
☐ White ☐ Hispanic or Latino
☐ Other ☐ Not Known

REPORTING SOURCE

Reporting Agency: _____ Reporter's Title: _____

Reporter's First Name: _____ Reporter's Last Name: _____

Reporter's Phone: _____ Did the reporter witness the incident? ☐ Yes ☐ No

INCIDENT INFORMATION (PAGE 1)

Critical Incidents		Non-Critical Incidents
☐ Suspected Abuse	☐ Serious Medication Error	☐ Minor Injury
☐ Suspected Neglect	☐ Natural or Expected Death	☐ Medication Error without Serious Outcome
☐ Suspected Exploitation	☐ Unnatural or Unexpected Death	
☐ Homicidal Ideation	☐ Suicidal Ideation	
☐ Missing Person	☐ Unplanned Hospital Admission	
☐ Event Involving Police/ Emergency Personnel Intervention	☐ Emergency Room or Emergency Department Visit	
☐ Three or More Non-Critical Incidents of the Same Incident Type in a 90 Calendar Day Period	☐ Other (describe):	

Level of Harm or Injury to the Waiver Participant: (Choose one)

☐ Level 1: None
☐ Level 2: Injury or harm requiring treatment up to and including first aid
☐ Level 3: Injury or harm requiring medical treatment beyond first aid, injury or harm requiring hospitalization
☐ Level 4: Injury or harm resulting in death

Date of Incident (MM/DD/YY): _____ Discovery Date (MM/DD/YY): _____

Time of Incident (AM/PM): _____ Discovery Time (AM/PM): _____

☐ Date and/or time of incident approximated

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INCIDENT INFORMATION (PAGE 2)

Location Type:

- ☐ Waiver Participant's Home
  - ☐ Living alone
  - ☐ Living with relatives
  - ☐ Living with unrelated person
  - ☐ Staffed residence
  - ☐ Family home provider
  - ☐ Adult foster care
  - ☐ Group home
- ☐ Community
  - ☐ Day program
  - ☐ Work
  - ☐ Vehicle
- ☐ Unknown
- ☐ Other Location (describe):

Name of Location: _____

Address of Incident: _____

_____

Briefly describe what happened (use the first and last name(s) of any staff involved and include specific dates and times):

NOTIFICATIONS

Entity	Contact Name from the Notified Entity	Notification Method			Notification Date and Time	
		Phone	Email/ Electronic	Fax	Date (MM/DD/YY)	Time (AM/PM)
☐ Law Enforcement		☐	N/A	N/A		
☐ DBHDID		N/A	☐	N/A		
☐ DAIL		N/A	☐	N/A		
☐ DMS		N/A	☐	N/A		
☐ Family Member		☐	☐	☐		
☐ State Guardian (GSSW)		☐	☐	☐		
☐ Private Guardian		☐	☐	☐		
☐ Direct Service Provider		☐	☐	☐		
☐ Medical Provider		☐	☐	☐		
☐ Case Manager/Support Broker/Service Advisor		☐	☐	☐		
☐ DCBS (APS/CPS) Intake # provided by DCBS: _____		☐	☐	N/A		
☐ Other		☐	☐	☐		

ALLEGED PERPETRATOR

For incidents involving alleged abuse, neglect, or exploitation, please supply the following information if available.

Alleged Perpetrator's Name: _____ Social Security # or other ID (if known): _____

Street Address: _____ City: _____ State: _____

Contact #: _____ Age: _____

Relationship to Impacted Waiver Participant:

☐ Relative ☐ Staff ☐ Peer ☐ Other (please specify):

_____

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WITNESSES

Witness Name	Address	Contact #	Relationship to Waiver Participant

RISK MITIGATION

1 What is the waiver participant's current status? (Choose one)

- ☐ Stable with no serious changes noted
- ☐ Seen by professional and returned home
- ☐ Seen by professional and admitted to facility (specify location and date below)
- ☐ Other, briefly describe:

2 Could this incident have been prevented? ☐ Yes ☐ No ☐ Unknown

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

- ☐ Track/monitor medical treatment (ER, doctor, hospital, etc.) to identify trends
- ☐ Track/monitor previous incidents to identify trends
- ☐ Modification of person-centered service plan
- ☐ Change in environmental factors
- ☐ Other, briefly describe:

3 Identify immediate actions to ensure health, welfare and safety of the waiver participant (Choose all that apply)

- ☐ Anticipate and observe for advance signs of and triggers for the incident
- ☐ Agency processes/procedures improvements
- ☐ Improve communication within the agency and between agencies
- ☐ Other, briefly describe:
- ☐ Team meeting

To be completed by the individual completing and submitting this form (may be reporter or other designated staff):

Printed Name/Title: _____ Signature: _____ Date (MM/DD/YY): _____