

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

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

- 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: \_\_\_\_\_ Race or Ethnicity:  
 Gender:  Male  Female  Unspecified  
 American Indian or Alaska Native  Asian  
 Black or African American  Pacific Islander  
 White  Hispanic or Latino  
 Diagnosis/Illnesses (if known): \_\_\_\_\_  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
<input type="checkbox"/> Suspected Abuse	<input type="checkbox"/> Serious Medication Error	<input type="checkbox"/> Minor Injury
<input type="checkbox"/> Suspected Neglect	<input type="checkbox"/> Natural or Expected Death	<input type="checkbox"/> Medication Error without Serious Outcome
<input type="checkbox"/> Suspected Exploitation	<input type="checkbox"/> Unnatural or Unexpected Death	Medication Refusal
<input type="checkbox"/> Homicidal Ideation	<input type="checkbox"/> Suicidal Ideation	
<input type="checkbox"/> Missing Person	Unplanned Hospital Admission	
<input type="checkbox"/> 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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<b>INCIDENT INFORMATION (PAGE 2)</b>	Location Type: <input type="checkbox"/> Waiver Participant's Home <input type="checkbox"/> Community <input type="checkbox"/> Living alone <input type="checkbox"/> Day program <input type="checkbox"/> Living with relatives <input type="checkbox"/> Work <input type="checkbox"/> Living with unrelated person <input type="checkbox"/> Vehicle <input type="checkbox"/> Staffed residence Family home provider <input type="checkbox"/> Unknown Adult foster care <input type="checkbox"/> Other Location (describe): Group home	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)
<input type="checkbox"/> Law Enforcement		<input type="checkbox"/>	N/A	N/A		
<input type="checkbox"/> DBHDID		N/A		N/A		
<input type="checkbox"/> DAIL		N/A	<input type="checkbox"/>	N/A		
<input type="checkbox"/> DMS		N/A	<input type="checkbox"/>	N/A		
<input type="checkbox"/> Family Member		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> State Guardian (GSSW)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Private Guardian		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Direct Service Provider		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Medical Provider		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Case Manager/Support Broker/Service Advisor		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> DCBS (APS/CPS) Intake # provided by DCBS: _____		<input type="checkbox"/>	<input type="checkbox"/>	N/A		
<input type="checkbox"/> Other						

<b>ALLEGED PERPETRATOR</b>	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: <input type="checkbox"/> Relative <input type="checkbox"/> Staff <input type="checkbox"/> Peer <input type="checkbox"/> Other (please specify): _____		

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	Witness Name	Address	Contact #	Relationship to Waiver Participant
WITNESSES	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
RISK MITIGATION				
1	What is the waiver participant's current status? (Choose one) <input type="checkbox"/> Stable with no serious changes noted <span style="margin-left: 150px;"><input type="checkbox"/> Seen by professional and admitted to facility (specify location and date below)</span> <input type="checkbox"/> Seen by professional and returned home <span style="margin-left: 150px;"><input type="checkbox"/> Other, briefly describe:</span>			
2	Could this incident have been prevented? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, then how could the incident have been prevented? (Choose one) <input type="checkbox"/> Track/monitor medical treatment (ER, doctor, hospital, etc.) to identify trends <span style="margin-left: 100px;"><input type="checkbox"/> Track/monitor previous incidents to identify trends</span> <input type="checkbox"/> Modification of person-centered service plan <span style="margin-left: 100px;"><input type="checkbox"/> Change in environmental factors</span> <input type="checkbox"/> Other, briefly describe:			
3	Identify immediate actions to ensure health, welfare and safety of the waiver participant (Choose all that apply) <input type="checkbox"/> Anticipate and observe for advance signs of and triggers for the incident <span style="margin-left: 100px;"><input type="checkbox"/> Agency processes/procedures improvements</span> <input type="checkbox"/> Improve communication within the agency and between agencies <span style="margin-left: 100px;"><input type="checkbox"/> Other, briefly describe:</span> <input type="checkbox"/> 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): \_\_\_\_\_