

## IOWA MEDICAID CRITICAL INCIDENT REPORT

(Please note: Select <b>Completed</b> ONLY when all investigative activities are complete and resolution activities have been implemented. Otherwise submit an initial report.) Report Status: <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Completed	
Reporting Party	National Provider Identifier _____ Provider (Name or Agency) _____ Provider Address _____ City _____ State _____ Zip _____ County _____ Phone # _____ Fax # _____ Reporter Name (Last) _____ (First) _____ (MI) _____ (Title) _____ (Email) _____
	Medicaid No: _____ Name: (Last) _____ (First) _____ (MI) _____ Address _____ City _____ State _____ Zip _____ County _____ Date of Birth: _____ Member's Gender: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female Case Manager Name: (Last) _____ (First) _____ (Email) _____ <div style="float: right;">           HCBS Waiver: <input type="checkbox"/> Elderly &amp; Handicapped <input checked="" type="checkbox"/> Chain Injury  <input type="checkbox"/> Physical Disability <input checked="" type="checkbox"/> Elderly  <input type="checkbox"/> Children's Mental Health  <input type="checkbox"/> Intellectually Disabled (formerly MR)            State Plan: <input type="checkbox"/> Habilitation <input checked="" type="checkbox"/> HRP         </div>
Incident Information	Date of Incident: _____ Time of Incident: _____ <input type="checkbox"/> _____ <input type="checkbox"/> unknown The Incident Was: <input checked="" type="checkbox"/> Discovered <input type="checkbox"/> Witnessed First staff person to learn of the incident: (Name) _____ (Title) _____
	Location where incident occurred: (select one) <input type="checkbox"/> <b>Member's Home</b> <input type="checkbox"/> Private residence/household – living alone <input type="checkbox"/> Private residence/household – living with relatives <input type="checkbox"/> Private residence/household – living with unrelated persons <input type="checkbox"/> Community supervised living <input type="checkbox"/> RCF <input type="checkbox"/> RCF/MH <input type="checkbox"/> RCF/PH <input type="checkbox"/> Assisted living <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Community</b> <input type="checkbox"/> Community job <input type="checkbox"/> School <input type="checkbox"/> Day program <input type="checkbox"/> Work activity <input type="checkbox"/> Homeless/shelter/street <input type="checkbox"/> Vehicle <input type="checkbox"/> Shopping <input type="checkbox"/> Dining <input type="checkbox"/> Operating <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Other Location</b> <input type="checkbox"/> State MH <input type="checkbox"/> State resource center <input type="checkbox"/> Correctional facility / jail <input type="checkbox"/> Foster care/family life home <input type="checkbox"/> RCF / nursing facility <input type="checkbox"/> RCF/MH <input type="checkbox"/> RCF/PH <input type="checkbox"/> Hospital / medical clinic <input type="checkbox"/> Other _____
	Other People Present (Provide name of person, initials if a member, and their relationship to the member) 1. _____ other <input type="checkbox"/> member staff <input type="checkbox"/> facility <input type="checkbox"/> roommate <input type="checkbox"/> neighbor other specify <input type="checkbox"/> 2. _____ other <input type="checkbox"/> member staff <input type="checkbox"/> facility <input type="checkbox"/> roommate <input type="checkbox"/> neighbor other specify <input type="checkbox"/> 3. _____ other <input type="checkbox"/> member staff <input type="checkbox"/> facility <input type="checkbox"/> roommate <input type="checkbox"/> neighbor other specify <input type="checkbox"/> 4. _____ other <input type="checkbox"/> member staff <input type="checkbox"/> facility <input type="checkbox"/> roommate <input type="checkbox"/> neighbor other specify <input type="checkbox"/>
	Services: (select one) <input type="checkbox"/> Services were not being provided. <input type="checkbox"/> Service being provided at the time of the incident: W code _____ Service Name _____ Describe the incident, including <b>Who, What, When, Where, and How.</b> (Describe any preceding circumstances, resulting harm to people, property damage, and any other relevant information. Include what was observed or heard. Attach additional pages if needed)
Immediate Resolution	Date of Immediate Resolution: _____ Type of Immediate Resolution: (select all that apply) <input type="checkbox"/> resolved by provider staff <input type="checkbox"/> in-patient hospitalization (medical unit) <input type="checkbox"/> resolved by case manager <input type="checkbox"/> incarceration <input type="checkbox"/> resolved by outside entity <input type="checkbox"/> resolved by natural supports <input type="checkbox"/> out-patient mental health <input type="checkbox"/> treatment by a health care professional <input type="checkbox"/> emergency room treatment <input type="checkbox"/> in-patient hospitalization (mental health unit)
	Describe the actions taken after the incident occurred to secure the member's safety.    Guardian: <input type="checkbox"/> yes <input type="checkbox"/> no    Guardian notified: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> attempted, unable to reach

# Iowa Incident Based Report Specifica

**Clifford Lane**



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