|  |
| --- |
| **PARTICIPANT IDENTIFYING INFORMATION:** |
| **Name First:** | **Name Middle (if known):** | **Name Last:**  |
|   |  |  |
| **Address:** | **City:**  | **State:**  | **Telephone #:** |
|  |  |  |  |
| **Region:** | **DOB:** | **SSN:**  |
|  |  |  |
| **Parish:**  | **Gender: [ ]  Male [ ]  Female** |
| **Name of Family or Legal Guardian:**  | **Telephone of Family or Legal Guardian:** |
|  |   |
| **Incident Occurred** Date:\_\_\_\_\_\_/Time:\_\_\_\_\_\_\_ [ ] AM or [ ] PM |
| **Incident Discovered**Date:\_\_\_\_\_\_/Time:\_\_\_\_\_\_\_\_ [ ] AM or [ ] PM | **Direct Service Provider Agency Name:** |
| **(Shaded Area for Use of DSP supervisor only)****Service Type:**[ ]  NOW- New Opportunities Waiver[ ]  CC- Children’s Choice Waiver[ ]  SW- Supports Waiver[ ]  ROW- Residential Options Waiver | **Living Situation:** [ ] Alone[ ] With Relative(s)[ ] With Roommate(s)[ ] With Spouse | **Legal Status:**[ ] Competent Major[ ] Interdicted[ ] Emancipated[ ] Minor[ ] Continued Tutorship |
| **Services at Time of Incident** | Natural Supports Present:[ ]  No[ ]  YesName(s): |
| Waiver Services Scheduled[ ]  No[ ]  Yes | Waiver Services Present[ ]  No[ ]  YesName(s) of Employee(s): |

|  |  |
| --- | --- |
| **Participant Name:** | **SSN:** |
|  |  |
| **INCIDENT CATEGORIES: Check those that apply****Note: All protective services allegations must be verbally reported** |
| **Note to Support Coordinator (SC)**: If the SC discovers/witnesses an Abuse, Neglect, Exploitation or Extortion incident involving a participant over the age of 18, the SC should immediately verbally report the incident to APS. The SC should complete the CIR and keep a copy for SCA record. Important: The SC shall not enter the information regarding APS Cases aged over 18 into the Incident System. This only applies to APS cases aged over 18. |
| **APS Incident Type (Participants 18 18 years and older)**[ ] Abuse[ ] Neglect[ ] Exploitation[ ] Extortion[ ] Self Neglect | **Age 0-17 years:****Child Abuse**[ ] Primary[ ] Non Primary**Child Neglect**[ ] Primary[ ] Non Primary | **CPS Confirmation:****ID of CPS Intake Worker:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | ***For use LGE personnel only:*****EPS Incident Type****(Participants 60 years and older):**[ ] Abuse[ ] Neglect[ ] Exploitation[ ] Extortion[ ] Self Neglect |
| [ ] **Major Injury** | [ ] **Fall** | [ ] **Death** | [ ] **Loss or Destruction of Home**  |
| [ ] **Major Illness***Also - check if Sub Category applies:*[ ]  Decubitis[ ]  Seizure[ ]  Pneumonia[ ]  Bowel  Obstruction | [ ] **Major Behavioral**  **Incident:**[ ] Suicidal Threats[ ] Missing Person[ ] Self-Injury[ ] Nonconsensual  Sexual Behavior[ ] Physical Aggression | [ ] **Major Medication** **Incident** [ ] Pharmacy Error[ ] Staff Error[ ] Family Error [ ] Participant Error [ ] Participant Non- compliance | [ ]  **Involvement with**  **Law Enforcement:**[ ] Participant arrested[ ] Law enforcement on site[ ] On duty staff arrested/charged[ ] On duty staff issued a citation for a moving violation  |
| **Restraints Use:** [ ] BEHAVIORAL [ ] Personal [ ] Mechanical [ ] Chemical [ ] MEDICAL [ ] Personal [ ] Mechanical [ ] Chemical  |
| **Participant Name:**  | **SSN:** |
|  |  |
| **EVENT INFORMATION**  |
| *(This space is not for incident* *Information)* | **Location of incident:**[ ] Home[ ] Community[ ] Facility[ ] Vehicle[ ] Day Program |
| [ ]  **DSP notified APS/EPS** Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] AM or [ ] PM[ ]  **DSP notified Law Enforcement** Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] AM or [ ] PM[ ]  **DSP notified C.P.** Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] AM or [ ] PM |
| **Type of Health Care Admissions and Date of Admissions (check all that apply):** |
| [ ] Emergency Room[ ] Acute Care Hospital[ ] Psychiatric Hospital | Date:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_  | [ ]  Urgent Care[ ]  Nursing Home | Date:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_ |
| **Reporter Name:**  |
| **Relationship:**[ ] Curator (adult)[ ] Day Program[ ] Direct Service Worker[ ] Parent [ ] Guardian (child) | [ ] OCDD Waiver office[ ] Provider [ ] Self [ ] Sibling [ ] Spouse | [ ] Support Coordinator[ ] Under Curator |  |
| **Support Coordination Agency:** | **Agency Telephone #:** |
|  |  |
| **Support Coordinator (SC) Name** | **SC Telephone #:** |
|  |  |
| **Direct Service Provider:** | **DSP Telephone #:** |
|  |  |

**HCBS Critical Incident Report Form**

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| --- | --- |
| **Participant Name:**  | **SSN:** |
|  |  |
| **Critical Incident Description:**Enter all information regarding the incident (i.e., who, what, when, where, how). Use as many pages as necessary, numbering, dating and signing each page. Include the name of the individual with the participant at the time of the incident (including relationship, telephone #). If law enforcement was notified, include the name of the agency, contact person, and address. (Character Limit: 1,000) |
| **Name of Direct Service Provider:** | **Date reported to SC:** | **Time:** |
|  |  |  |
| **Report completed by:** | **Telephone #:** | **Date:** | **Region** |
|  |  |  |  |

**Critical Incident Report Description – DSP Follow-Up**

Use as many copies of this form as needed to complete your report. Each additional page must be signed and dated

|  |  |
| --- | --- |
| **Participant Name:**  | **SSN:** |
|  |  |
| **If participant was released from a facility or outpatient procedure, indicate date and time of release:**Date:\_\_\_\_\_\_/Time:\_\_\_\_\_\_\_ [ ] AM or [ ] PM **FOR SC USE ONLY:** *Meets criteria for Major Medical Event/major illness:* [ ] Yes or [ ] No |
| **Direct Service Provider Follow-up**

|  |
| --- |
| *Follow-up admission* and date **after** initial health care contact (if applicable): |
| [ ] Acute Care Hospital[ ] Psychiatric Hospital[ ] Rehabilitation Facility[ ] Nursing Home | Date:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_ | [ ] Respite Center[ ] Pinecrest SSC[ ] Hospice: center-based | Date:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_ |

Enter any follow-up related to remediating the critical incident such as modifications to environment, outcome of health care appointments, labs, discharge instructions from hospital, change in staffing, medications, treatments, team meetings, or revisions to Plan of Care. |
| **Name of Direct Service Provider:** | **Date reported to SC:** | **Time:** |
|  |  |  |
| **Follow-up completed by:** | **Telephone #:** | **Date:** | **Region** |
|  |  |  |  |

Attach **Supplemental Form** to continue Critical Incident Report Description as necessary. Each additional page **must** be signed and dated. Additional space for incident description and follow-up.