|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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  Yes  Name(s): | | |
| Waiver Services Scheduled  No  Yes | Waiver Services Present  No  Yes  Name(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**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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.