

## 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 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 Member	Medicaid No: _____ Name: (Last) _____ (First) _____ (MI) _____ Address _____ City _____ State _____ Zip _____ County _____ Date of Birth: _____ Member's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Case Manager Name: (Last) _____ (First) _____ (Email) _____	HCBS Waiver: <input type="checkbox"/> Aids/HIV <input type="checkbox"/> IR & Handicapped <input type="checkbox"/> Brain Injury <input type="checkbox"/> Physical Disability <input type="checkbox"/> Elderly <input type="checkbox"/> Children's Mental Health <input type="checkbox"/> Intellectually Disabled (formerly MR) State Plan: _____ Grants: _____ <input type="checkbox"/> Habilitation <input type="checkbox"/> MFP
Incident Information	Date of Incident: _____ Time of Incident: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unknown The Incident Was: <input 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/MR <input type="checkbox"/> RCF/PMI <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"/> recreating <input type="checkbox"/> other _____	
	<input type="checkbox"/> <b>Other Location</b> <input type="checkbox"/> state MHI <input type="checkbox"/> state resource center <input type="checkbox"/> correctional facility / jail <input type="checkbox"/> foster care/family life home <input type="checkbox"/> SCF / nursing facility <input type="checkbox"/> SCF/MR <input type="checkbox"/> SCF/PMI <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. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 2. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 3. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 4. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____	
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 <b>all</b> 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 Dhs Medicaid Report

**Zhe Xu**

A red circular graphic with a gradient, appearing as a semi-circle or a partial circle, located to the right of the author's name.

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