UnitedHealthcare Community Plan

Critical Incident Reporting Form

This form must be received within **24 hours** of discovery of the incident.

Please complete this form and fax to the Quality Management Department along with any other supporting documentation to: **855-216-6408**

Other important numbers

NJ APS ph**:** 609-588-6501 **OOIE** fax:1-877-585-6995 **DCP&P/ DC&P** ph**:** 877-652-2873

SECTION 1: Member Information (complete all sections)				
Subscriber ID#: **Medicaid ID#:**	**Member Name:**	**DOB:**	**Gender**:	**Member Address**:
UHC Care Coordinator for member:				

SECTION 2: Critical Incident Information (complete all sections)	
Date/Time Incident Occurred:	**Date/Time Provider or UHC rep (CC etc) first learned of incident (discovery):**
Date/Time Reported to UnitedHealthcare Clinical Quality Analyst:	
Who first reported incident to provider or UHC rep: ☐ Member, ☐ POA/family, ☐ Worker, Other:	
Location of Incident: ☐ Community/General Public Area ☐ Facility-Based Setting ☐ Private Home ☐Other:_____	**Provider Type:** ☐ Community Living Facility Providers (AFC, ALR, CPCH, ALP, CRS) ☐ Day Services Providers (SADC, SDP, SDS, MDS – Pediatric and Adult) ☐ Home Care Providers (HCBS, HDM, CS, MDD, PERS, IHR) ☐ Home Health Providers (PDN, PCA) ☐ Individualized Service Providers (RM, VM, NMT, C/PT,CTS) ☐ LTC Facility Providers (NF, SCNF, CC, RC) ☐ TBI Behavioral and Cognitive Therapy (Group and Individual) ☐ Therapy Providers (OT, PT, S, LHT)
Primary Medical Complexity: (*check all that apply*) ☐ Heart Condition (i.e. CVA, Hypertension, CHF) ☐ Muscular/Skeletal (i.e. Arthritis, Fracture) ☐ Neurological (i.e. Alzheimer's, MS, Head Trauma, Quadriplegia, Seizure Disorder)	☐ Psychiatric/Mood (i.e. Anxiety, Depression, Behavioral/Mental Illness, Psych Diagnosis) ☐ Pulmonary (i.e. Emphysema, Asthma, COPD) ☐ Sensory (i.e. Vision/Hearing Impaired) ☐ Infections (i.e. Pneumonia, TB, UTI) ☐ Other Diseases (i.e. Renal Failure, Cancer)

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Relationship of Alleged Perpetrator:

- ☐ Authorized Representative
- ☐ Brother
- ☐ Daughter
- ☐ Daughter-In-Law
- ☐ Father
- ☐ Friend or Neighbor (non-caretaker)
- ☐ Granddaughter
- ☐ Grandson
- ☐ Guardian
- ☐ Mother
- ☐ Other Relative
- ☐ No Relationship/Stranger
- ☐ Power of Attorney
- ☐ Self
- ☐ Self-Direction Provider
- ☐ Service Provider
- ☐ Sister
- ☐ Son
- ☐ Son-In-Law
- ☐ Spouse/Intimate Partner

Incident / Alleged Incident Type:

- ☐ Unexpected death of a member
- ☐Media involvement or the potential for media involvement
- ☐ Physical abuse (including seclusion and restraints both physical and chemical)
- ☐ Psychological / Verbal abuse
- ☐ Sexual abuse and/or suspected sexual abuse
- ☐ Fall resulting in the need for medical treatment
- ☐ Medical emergency resulting in need for medical treatment
- ☐ Medication error resulting in serious consequences
- ☐ Psychiatric emergency resulting in need for medical treatment
- ☐ Severe injury resulting in the need for medical treatment
- ☐ Suicide attempt resulting in the need for medical attention
- ☐ Neglect/Mistreatment, caregiver (paid or unpaid)
- ☐ Neglect/Mistreatment, self
- ☐ Neglect/Mistreatment, other
- ☐ Exploitation, financial
- ☐ Exploitation, theft
- ☐ Exploitation, destruction of property
- ☐ Exploitation, other
- ☐ Theft with law enforcement involvement
- ☐ Failure of member's Back-up Plan
- ☐ Elopement/Wandering from home or facility
- ☐ Inaccessible for initial/on-site meeting
- ☐ Unable to Contact
- ☐ Inappropriate or unprofessional conduct by a provider involving member
- ☐ Cancellation of utilities
- ☐ Eviction/loss of home
- ☐ Facility closure, with direct impact to member's health and welfare
- ☐ Natural disaster, with direct impact to member's health and welfare
- ☐ Operational Breakdown
- ☐ Other (explain below)

_____

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Description of Incident (submit additional pages if needed):

Explain the Relationship of the CI to the member's present health Status: *Is there a Risk Assessment Agreement? Was the backup plan on members Plan of Care? Does the backup plan need to change?*

If CI inflicted by another individual, identify alleged offender's name (if possible): _____
Document Relationship of alleged offender and Member: ☐ Power of Attorney, ☐ Authorized Representative, ☐ Guardian, ☐ Self-Direction Provider

Actions taken immediately to mitigate risk to Member: (what you did to ensure member's safety within 24 hrs. Please list dates and times of attempts to contact these agencies, if faxed please save confirmation)

☐ **911/EMS** notified
☐ **APS** notified if incident involves an Adult either suspected or actual physical, mental, sexual abuse, or exploitation.
☐ **Accrediting Agency** notified
☐ **DDD** notified
☐ **DOH** Facility Hotline notified
☐ **OOIE** notified if incident involves an Adult in a Nursing Home involved either suspected or actual physical, mental, sexual abuse or exploitation.
☐ **DCP&P/DC&P** notified if incident involves a Child either suspected or actual physical, mental, sexual abuse, neglect or financial exploitation.
☐ Accused worker removed from home and from providing care to UHC member pending investigation
☐ New worker assigned to provide services
☐ Family member/POA notified
☐ Other-please describe _____
_____
_____

Critical Incident Resolved at the Time of the Report? ☐ Yes ☐ No

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Person submitting this report:

Name	**Telephone number(s) where you can be reached if more information is needed**	
Title and Company name	**Email address**	**Date THIS FORM submitted to UHC**

Updated 7/1/2016