Critical Incident Report Form

UnitedHealthcare Community Plan

Please complete and submit this form to UnitedHealthcare Community Plan:

- When you report abuse, neglect or exploitation of a UnitedHealthcare Community Plan member to the Texas Department of Family and Protective Services (DFPS), or
- When you become aware of a critical incident (including abuse, neglect or exploitation) related to a UnitedHealthcare Community Plan member.

This notification should not take the place of reporting to DFPS (800-252-5400 or TXAbuseHotline.org). For more information, please view our training on **Critical Incident Reporting: Including Abuse, Neglect and Exploitation**.

Submit this form by:

- Email — **critical_incidents@uhc.com**
- Fax — **855-371-7638**

If you need assistance completing the form, please contact your provider advocate or email us at critical_incidents@uhc.com. Thank you.

Member's name:

Member's UnitedHealthcare Community Plan ID number:

Member's address:

Member's date of birth:

Member's UnitedHealthcare Community Plan benefit plan (choose one):

- ☐ Children's Health Insurance Program (CHIP)
- ☐ STAR
- ☐ STAR+Plus
- ☐ STAR Kids
- ☐ UnitedHealthcare Connected® (Medicare-Medicaid Plan)
- ☐ UnitedHealthcare Dual Complete® (Special Needs Plan)
- ☐ Unknown

Is the member on a waiver (choose one)? ☐ Yes ☐ No ☐ Unknown

Service area where the member lives (choose one):

- ☐ Jefferson
- ☐ Harris
- ☐ Hidalgo
- ☐ Medicaid Rural Service Area Central
- ☐ Medicaid Rural Service Area Northeast
- ☐ Nueces
- ☐ Travis
- ☐ Unknown

Choose the type of incident (choose one):

- ☐ Abuse
- ☐ Neglect
- ☐ Exploitation
- ☐ Unauthorized use of restraint, seclusion, or restrictive interventions
- ☐ Serious injury that resulted in medical intervention or hospitalization
- ☐ Criminal victimization
- ☐ Death
- ☐ Other (please describe):

Describe the incident (attach another sheet if necessary).

Describe any actions taken as a result of incident.

Who caused the incident (if applicable)?

Name of the person who first became aware of the incident and their relationship to the member:

Where did the incident occur (choose one)?

- ☐ Family home
- ☐ Group home or assisted living facility
- ☐ Medical facility
- ☐ Nursing facility
- ☐ School
- ☐ Place of employment
- ☐ Other (please describe):

Incident date:	**Incident time:**

Was the incident reported to local emergency authorities? ☐ Yes. When?_____ ☐ No

Was the incident reported to the Texas Department of Family and Protective Services?

☐ Yes. When?_____ ☐ No

Your name:

Your relationship to the member:

Your or your agency's tax identification number:

Your or your agency's email address:

Which best describes you or your agency?

- ☐ Long Term Services and Support (LTSS) (please describe below)
- ☐ Primary care provider
- ☐ Specialty provider (please describe below)
- ☐ Other (please describe below)

Date you completed this form:

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