

DEPARTMENT OF HEALTH SERVICESDivision of Long Term Care
F-22541 (06/2010)**STATE OF WISCONSIN**

Completion of this form meets the requirements and conditions of the CMS-approved Medicaid Waiver programs

INCIDENT REPORT – MEDICAID WAIVER PROGRAMS

Instructions: This form may be completed in stages but must eventually be completed in its entirety. It is applicable to all children and adults receiving services through the BI, CLTS, CIP 1A/1B, COR and IRIS Medicaid Waiver programs. Additional information may be attached to supplement but not replace information provided on the report form. This form must be submitted via mail or FAX to the designated Contact for the specific Waiver program. Failure to report incidents as required or in a timely manner may result in a full or partial disallowance of the funding claimed for the subject of the incident if it is determined that the participant's safety was not assured by the waiver agency.

TIMELINES: If a Critical Incident, report to waiver agency WITHIN 24 HOURS. Agencies: Notify state contact staff within THREE BUSINESS DAYS of the initial report. For additional requirements, see the instructions ([F-22541I](#))

PARTICIPANT INFORMATION

1. Name - Last		Name - First	MI
2. Address – Street (Participant)		City / State / Zip Code	
3. Birthdate	4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Telephone Number ()	
6. Name – Residential Service Provider		Address – Residential Service Provider	
7. County of Physical Residence		8. County of Fiscal Responsibility	
9. Waiver Program <input type="checkbox"/> CLTS <input type="checkbox"/> DD <input type="checkbox"/> PD <input type="checkbox"/> SED <input type="checkbox"/> CIP 1A <input type="checkbox"/> CIP 1B <input type="checkbox"/> BIW <input type="checkbox"/> IRIS <input type="checkbox"/> Other –specify:			10. Waiver Slot Number: (CLTS only)

INCIDENT INFORMATION

11. Date of Event	12. Location Event Occurred (Street, City, State, Zip Code)		
13. Name – Reporting Provider (Individual / Agency)		Reporting Provider Contact Information (Telephone No., E-mail)	
14. Type of Report (Check all that apply) <input type="checkbox"/> Critical <input type="checkbox"/> Original <input type="checkbox"/> Update <input type="checkbox"/> Correction <input type="checkbox"/> Incident Review Completed and Closed			
15. Type of Setting Where Incident Likely Occurred			
Residence			
<input type="checkbox"/> Natural or adoptive home (with parents)	<input type="checkbox"/> Adult family home, 1-2 bed		
<input type="checkbox"/> Person's own home	<input type="checkbox"/> Adult family home, 3-4 bed		
<input type="checkbox"/> Children's foster home / treatment foster home	<input type="checkbox"/> CBRF		
Other			
<input type="checkbox"/> School	<input type="checkbox"/> Respite provider site		
<input type="checkbox"/> Child care center	<input type="checkbox"/> Another person's residence		
<input type="checkbox"/> Work site in community	<input type="checkbox"/> Waiver transportation provider, public		
<input type="checkbox"/> Work site—congregate vocational provider	<input type="checkbox"/> Waiver transportation provider, agency or individual		
<input type="checkbox"/> Day activity site	<input type="checkbox"/> Public transportation provider- not waiver funded		
<input type="checkbox"/> Day treatment program	<input type="checkbox"/> Other – Specify:		
<input type="checkbox"/> Community Setting—park, store, etc.			

EVENT / ALLEGATION CHECKLIST

16. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is uncertainty about whether the event occurred.

<u>Event Type / Allegation</u>	<u>Alleged Only</u>	<u>Event Type / Allegation</u>	<u>Alleged Only</u>
<u>Abuse</u>		<u>Neglect (Cont'd)</u>	
<input type="checkbox"/> Mental / emotional	<input type="checkbox"/>	<input type="checkbox"/> Medical / failure to seek	<input type="checkbox"/>
<input type="checkbox"/> Physical	<input type="checkbox"/>	<input type="checkbox"/> Nutrition	<input type="checkbox"/>
<input type="checkbox"/> Sexual	<input type="checkbox"/>	<input type="checkbox"/> Unsafe or unsanitary environmental conditions	<input type="checkbox"/>
<input type="checkbox"/> Verbal	<input type="checkbox"/>	<input type="checkbox"/> Self-neglect	<input type="checkbox"/>
<input type="checkbox"/> Misappropriation of the person's funds or property	<input type="checkbox"/>	<input type="checkbox"/> Unanticipated absence of provider	<input type="checkbox"/>
		<input type="checkbox"/> Error in medication resulting in significant reaction requiring medical attention	<input type="checkbox"/>
<u>Death</u>		<u>Other</u>	
<input type="checkbox"/> Accidental	<input type="checkbox"/>	<input type="checkbox"/> Unexpected serious illness / injury / accident	<input type="checkbox"/>
<input type="checkbox"/> Anticipated	<input type="checkbox"/>	<input type="checkbox"/> Unexpected, untimely, urgent, emergency hospitalization	<input type="checkbox"/>
<input type="checkbox"/> Unanticipated	<input type="checkbox"/>	<input type="checkbox"/> Overdose of drugs or alcohol by participant	<input type="checkbox"/>
<input type="checkbox"/> Related to psychotropic medication*	<input type="checkbox"/>	<input type="checkbox"/> Unexpected significant behavior, not addressed in a behavior support plan	<input type="checkbox"/>
<input type="checkbox"/> Related to restraint or seclusion*	<input type="checkbox"/>	<input type="checkbox"/> Emergency / unplanned use of isolation/ seclusion / restraint	<input type="checkbox"/>
<input type="checkbox"/> Related to Suicide*	<input type="checkbox"/>	<input type="checkbox"/> Misuse of restraint or other restrictive measure	<input type="checkbox"/>
NOTE: *Deaths related to above factors in a licensed or certified facility must be reported to the Department Death Review Committee within 24 hours.		<input type="checkbox"/> Suicide attempt	<input type="checkbox"/>
<u>Law Enforcement Related</u>		<input type="checkbox"/> Significant damage to property	<input type="checkbox"/>
<input type="checkbox"/> Commission of crime	<input type="checkbox"/>	<input type="checkbox"/> Fire	<input type="checkbox"/>
<input type="checkbox"/> Victim of crime	<input type="checkbox"/>	<input type="checkbox"/> Unanticipated absence of participant	<input type="checkbox"/>
<input type="checkbox"/> Arrest or incarceration	<input type="checkbox"/>	<input type="checkbox"/> Other—Please describe	<input type="checkbox"/>
<u>Neglect</u>			
<input type="checkbox"/> Environmental	<input type="checkbox"/>		
<input type="checkbox"/> Fail to follow plan / poor care	<input type="checkbox"/>		

17. Provide Brief Description of incident:

18. Describe action taken to date as a result of the incident to resolve incident and assure health and safety of participant:

IF THE PARTICIPANT DIED, COMPLETE THE FOLLOWING:

19. Date of Death | 20. Official cause of death as reported on the death certificate

CONTACT / SUPPLEMENTAL REPORTING CHECKLIST

21. Check all persons / agencies contacted by county waiver agency

<input type="checkbox"/> A. Child Protective Services	<input type="checkbox"/> G. Law Enforcement Agency
<input type="checkbox"/> B1. Adult Protective Services	<input type="checkbox"/> H. Licensing Agency
<input type="checkbox"/> B2. Wisconsin Incident Tracking Report Submitted	<input type="checkbox"/> I. Physician
<input type="checkbox"/> C. CSS / Children's Services Specialist (Required for CLTS Waiver)	<input type="checkbox"/> J. Provider Agency
<input type="checkbox"/> D. Community Integration Specialist / CIS (Required for CIP 1A / 1B)	<input type="checkbox"/> K. DHS Waiver Manager / Central Office
<input type="checkbox"/> E. IRIS Independent Consultant	<input type="checkbox"/> L. Caregiver Misconduct Statewide Complaint Hotline: 800-642-6552
<input type="checkbox"/> F. Parent / Guardian (Required)	<input type="checkbox"/> M. Other—Specify: _____
	<input type="checkbox"/> N. Note any person / entity NOT notified and why: _____

22. Was the perpetrator / alleged perpetrator a paid service provider for subject of incident or was he/she an unpaid provider?

- Paid provider Unpaid Provider NA

23. Name – Caregiver involved where incident occurred.

24. Name – Employer of the caregiver involved when incident occurred

25. Address of Provider Agency employing the caregiver (Street, City, State, Zip Code)

OUTCOME AND CONCLUSION

26. Please provide a detailed description of the significant actions and events (e.g., staff terminated, arrested, etc.; person treated at ER) taken by all parties involved and their effects following the incident.

27. Please discuss changes to the waiver participant’s situation or status as a result of the incident including revisions to the person’s individualized service plan, provider/staff, living arrangement, school, work, guardian, etc., and how these changes assure the participant’s safety and improve his/her quality of life.

28. Type of change made or action taken by County/Waiver Agency or contractor as a result of Incident (check all that apply)

- | | |
|--|---|
| a. <input type="checkbox"/> Nothing changed | i. <input type="checkbox"/> Medically related consult |
| b. <input type="checkbox"/> Corrective action initiated | m. <input type="checkbox"/> Behavioral consult |
| c. <input type="checkbox"/> Terminate staff | n. <input type="checkbox"/> Staff providing training related to subject of incident |
| d. <input type="checkbox"/> Change in personnel working with the participant | o. <input type="checkbox"/> Refer to Licensing (Children’s) |
| e. <input type="checkbox"/> Added staff coverage | p. <input type="checkbox"/> Refer to Licensing (Adult) |
| f. <input type="checkbox"/> Change agency that provides service | q. <input type="checkbox"/> Report to CPS |
| g. <input type="checkbox"/> Change to Individualized Service Plan | r. <input type="checkbox"/> Report to APS |
| h. <input type="checkbox"/> Added new service | s. <input type="checkbox"/> Report/Refer to caregivers |
| i. <input type="checkbox"/> Reduced service | t. <input type="checkbox"/> Refer to Disability Rights Wisconsin |
| j. <input type="checkbox"/> Terminated service | u. <input type="checkbox"/> Refer to District Attorney/law enforcement agency |
| k. <input type="checkbox"/> Increased amount and/or type of external monitoring of setting | v. <input type="checkbox"/> Other – Specify: _____ |

NOTIFICATION OF INCIDENT

29. Date Form Completed	30. Name - Primary Children’s Services Specialist, Community Integration Specialist or person’s chosen Independent Consultant.
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31. Date of initial notification

32. Original Reporter:

- | | |
|--|---|
| <input type="checkbox"/> Waiver Participant | <input type="checkbox"/> Guardian (Can check other choices if this choice is checked) |
| <input type="checkbox"/> Parent | <input type="checkbox"/> Other Family Member |
| <input type="checkbox"/> Staff in Provider Agency | <input type="checkbox"/> Staff in other Provider Agency |
| <input type="checkbox"/> Support and Service Coordinator / Broker | <input type="checkbox"/> Independent Consultant (IRIS only) |
| <input type="checkbox"/> State / County Licensing or Certification Staff | <input type="checkbox"/> Other Governmental (e.g., law enforcement) |
| <input type="checkbox"/> Anonymous Complaint | <input type="checkbox"/> Independent Provider / Non-Agency Staff |
| <input type="checkbox"/> Other Community Member | <input type="checkbox"/> Other: Specify: _____ |

PERSON COMPLETING FORM INFORMATION

33. Name - Last	Name - First
34. Title	Name of Agency
35. E-Mail Address	36. Telephone Number ()

SUPPORT & SERVICE COORDINATOR / INDEPENDENT CONSULTANT / BROKER INFORMATION (If different from above)

37. Name – Last	Name - First	38 Telephone Number ()
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39. E-Mail address

40. Agency of Affiliation (If applicable)

I affirm that the information provided on this report accurately reflects the information obtained by the worker or agency in investigating the incident and that I have not withheld information concerning this incident.

SIGNATURE – Person Reporting

PRINT Name

Date Signed