**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Care and Treatment Services Completion of this form meets the

F-00390 (08/2016) requirements and conditions of the

CMS-approved CRS Benefit

**INCIDENT REPORT – COMMUNITY RECOVERY SERVICES**

**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 Community Recovery Services Medicaid benefit.** 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 CRS benefit. 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 CRS county/tribe agency WITHIN 24 HOURS. Agencies: Notify CRS state contact staff within THREE BUSINESS DAYS of the initial report. For additional requirements, see the instructions**

**(**[**F-00390I**](http://dhs.wisconsin.gov/forms/f0/f00390i.pdf)**)**

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| **PARTICIPANT INFORMATION** | | | | | | | |
| 1. Name - Last | | | | Name - First | | MI | |
| 2. Address – Street (Participant) | | | | City / State / Zip Code | | | |
|  | | | |  | | | |
| 3. Birthdate | 4. Gender  Male  Female | | | 5. Telephone Number  (   ) | | | |
| 6. Name – Residential Service Provider | | | | Address – Residential Service Provider | | | |
| 7. County of Physical Residence | | | | 8. County of FiscalResponsibility | | | |
| 9. CRS Authorized Services  Community Living Supportive Services (CLSS)  Peer Supports  Supported Employment | | | | CRS Service Definitions can be found on the CRS Website or the State Plan Amendment (SPA) | | | |
| **INCIDENT INFORMATION** | | | | | | | |
| 10. Date of Event | | 11. Location Event Occurred (Street, City, State, Zip Code) | | | | | |
| 12. Name – Reporting Provider (Individual / Agency) | | | | Reporting Provider Contact Information (Telephone No., E-mail) | | | |
| 13. **Type of Report** (Check all that apply)  Critical  Original  Update  Correction  Incident Review Completed and Closed | | | | | | | |
| 14. **Type of Setting Where Incident Likely Occurred** | | | | | | |
| **Residence**  Natural or adoptive home (with parents)  Person’s own home  Children's foster home | | | Adult family home, 1-2 bed  Adult family home, 3-4 bed  CBRF  RCAC  Supported Apartment | | | |
| **Other**  Work site in community  Day activity site  Community setting-park, store, etc.  Transportation provider, public  Transportation provider, agency or individual  Public transportation provider  Another person's residence | | |  | | | |
|  | | | Other – Specify: | |  | |

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| **EVENT / ALLEGATION CHECKLIST** | | | | | | | |
| 15. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is uncertainty about whether the event occurred. | | | | | | | |
| **Event Type / Allegation** | | | **Alleged**  **Only** |  | **Event Type / Allegation** | | **Alleged**  **Only** |
| Abuse | | |  |  | Neglect (Cont’d) | |  |
|  | Mental / emotional | |  |  |  | Medical / failure to seek |  |
|  | Physical | |  |  |  | Nutrition |  |
|  | Sexual | |  |  |  | Unsafe or unsanitary environmental  conditions |  |
|  | Verbal | |  |  |  |  |  |
|  | Misappropriation of the person’s funds or  property | |  |  |  | Self-neglect |  |
|  |  | |  |  |  | Unanticipated absence of provider |  |
|  | |  |  |  |  | Error in medication resulting in significant  reaction requiring medical attention |  |
| Death | | |  |  |  |  |  |
|  | Accidental | |  |  |  | Financial Exploitation |  |
|  | Anticipated | |  |  | Other | |  |
|  | Unanticipated | |  |  |  | Unexpected serious illness / injury / accident |  |
|  | Related to psychotropic medication\* | |  |  |  | Unexpected, untimely, urgent, emergency  hospitalization |  |
|  | Related to restraint or seclusion\* | |  |  |  |  |  |
|  | Related to Suicide\* | |  |  |  | Overdose of drugs or alcohol **by participant** |  |
| **NOTE**: \*Deaths related to above factors in a licensed or certified facility must be reported to the Department Death Review Committee within 24 hours. | | |  |  |  | Unexpected significant behavior, not  addressed in a treatment plan or Individualized Service Plan (ISP) |  |
|  | | |  |  |  |  |  |
|  | | |  |  |  | Emergency / unplanned use of isolation/  seclusion / restraint |  |
|  |  | |  |  |  |  |  |
| Law Enforcement Related | | |  |  |  | Misuse of restraint or other restrictive  measure |  |
|  | Commission of crime | |  |  |  |  |  |
|  | Victim of crime | |  |  |  | Suicide attempt |  |
|  | Arrest or incarceration | |  |  |  | Significant damage to property |  |
|  |  | |  |  |  | Fire |  |
| Neglect | | |  |  |  | Unanticipated absence of participant |  |
|  | Environmental | |  |  |  | Other—Please describe |  |
|  | Fail to follow plan / poor care | |  |  |  |  |  |
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| 16. Provide Brief Description of incident: | | | | | | | | | | | | |
| 17. 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:** | | | | | | | | | | | | |
| 18. Date of Death | | | | 19. Official cause of death as reported on the death certificate | | | | | | | | |
| **CONTACT / SUPPLEMENTAL REPORTING CHECKLIST** | | | | | | | | | | | | |
| 20. Check all persons / agencies contacted by CRS county/tribe provider agency | | | | | | | | | | | | |
|  |  | A. Child Protective Services | | |  | F. Licensing Agency | | | | | | |
|  |  | B1. Adult Protective Services | | |  | H. Physician | | | | | | |
|  |  | B2. Wisconsin Incident Tracking Report Submitted | | |  | I. Provider Agency | | | | | | |
|  |  | C. CSS / Children’s Services Specialist | | |  | J. DHS CRS Coordinator | | | | | | |
|  |  | (Required for CLTS Waiver) | | |  | K. Caregiver Misconduct Statewide Complaint Hotline: 800-642-6552 | | | | | | |
|  |  | D. Parent / Guardian (Required) | | |  | L. Other—Specify: | | |  | | | |
|  |  | E. Law Enforcement Agency | | |  | M. Note any person / entity **NOT notified** and why | | | |  | | |
|  | | | | | | | | | | | | |
| 21. 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 | | | | | | | | | | | | |
| 22. Name – Caregiver involved where incident occurred. | | | | | | | | | | | | |
| 23. Name – Employer of the caregiver involved when incident occurred | | | | | | | | | | | | |
| 24. Address of Provider Agency employing the caregiver (Street, City, State, Zip Code) | | | | | | | | | | | | |
| **OUTCOME AND CONCLUSION** | | | | | | | | | | | | |
| 25. 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. | | | | | | | | | | | | |
| 26. Please discuss changes to the CRS 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. | | | | | | | | | | | | |
| 27. Type of change made or action taken by CRS County/Tribe Agency or contractor as a result of Incident (check all that apply) | | | | | | | | | | | | |
| 1. Nothing changed 2. Corrective action initiated 3. Terminate staff 4. Change in personnel working with the participant 5. Added staff coverage 6. Change agency that provides service 7. Change to Individualized Service Plan 8. Added new service 9. Reduced service 10. Terminated service 11. Increased amount and/or type of external monitoring of setting | | | | | | | | 1. Medically related consult 2. Behavioral consult 3. Staff providing training related to subject of incident 4. Refer to Licensing (Children’s) 5. Refer to Licensing (Adult) 6. Report to Child Protective Services 7. Report to Adult Protective Services 8. Report/Refer to caregivers 9. Refer to Disability Rights Wisconsin 10. Refer to District Attorney/law enforcement agency | | | | |
|  | | | | | | | | 1. Other – Specify: | | |  | |
|  | | | | | | | |  | | |  | |
| **NOTIFICATION OF INCIDENT** | | | | | | | | | | | | |
| 27. Date Form Completed | | | 28. Name - CRS Care Manager. | | | | | | | | | |
| 29. Date of initial notification | | | | | | | | | | | | |
| 30. Original Reporter:  CRS Participant  Guardian (Can check other choices if this choice is checked)  Parent  Other Family Member  Staff in Provider Agency  Staff in other Provider Agency  Care Manager  State / County Licensing or Certification Staff  Other Governmental (e.g., law enforcement)  Anonymous Complaint  Independent Provider / Non-Agency Staff  Other Community Member  Other: Specify: | | | | | | | | | | | | |
| **PERSON COMPLETING FORM INFORMATION** | | | | | | | | | | | | |
| 31. Name - Last | | | | | | | Name - First | | | | | |
| 32. Title | | | | | | | Name of Agency | | | | | |
| 33. E-Mail Address | | | | | | | | | | | | 34. Telephone Number  (   ) |
| 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. | | | | | | | | | | | | |
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|  | **SIGNATURE** – Person Reporting |  | **PRINT** Name |  | Date Signed |

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| **STATE MEDICAID AGENCY CRS RECEIPT, REVIEW, ACTION TAKEN** |

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| 35. Name – SMA CRS Reviewer | 36. Date Received | | 37. Date Reviewed |
| 38. Action Taken | | | |
| 39. **SIGNATURE** - SMA CRS Reviewer | | Date Signed | |