**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Completion of this form meets the

F-22541 (07/2020) requirements and conditions of the

 CMS-approved Medicaid Waiver programs

**INCIDENT REPORT – IRIS**

**Instructions: This form may be completed in stages but must eventually be completed in its entirety. It is applicable to all participants receiving services through the IRIS program.** Additional information may be attached to supplement but not replace information provided on the report form. This form must be uploaded to the participant’s WISITS document library, as well as entered and saved in your agency’s Critical Incident site on SharePoint. Failure to report incidents as required or in a timely manner may result in issuance of an improvement plan, corrective action, and/or negative findings in the record review process for the IRIS consultant 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.**

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| **PARTICIPANT INFORMATION** |
| 1. Name – Last       | Name – First      | MI  |
| 2. Address – Street (Participant) | City / State / Zip Code |
|        |       |
| 3. Date of Birth       | 4. Sex[ ] [ ]  Male [ ] [ ]  Female  | 5. Telephone Number       |
| 6. Name – Residential Service Provider       | Address – Residential Service Provider      |
| 7. County of Physical Residence       | 8. County of FiscalResponsibility      |
| 9. MCI Number      |
| **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., Email)      |
| 14. **Type of Report** (Check all that apply) [ ]  Critical [ ]  Original [ ]  Update [ ]  Correction [ ]  Incident Review Completed and Closed |
| 15. **Type of Setting Where Incident Likely Occurred** |
|  **Residence** [ ] [ ]  Natural or adoptive home (with parents) [ ] [ ]  Person’s own home  | [ ] [ ]  Adult family home, 1-2 bed[ ] [ ]  Adult family home, 3-4 bed[ ] [ ]  CBRF |
|  **Other** [ ] [ ]  School [ ] [ ]  Child care center [ ] [ ]  Work site in community [ ] [ ]  Work site—congregate vocational provider [ ] [ ]  Day activity site [ ] [ ]  Day treatment program [ ]  Community Setting—park, store, etc. | [ ] [ ]  Respite provider site[ ]  Another person's residence[ ]  Waiver transportation provider, public[ ]  Waiver transportation provider, agency or individual [ ]  Public transportation provider- not waiver funded |
|  | [ ]  Other – Specify: |       |

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| **EVENT / ALLEGATION CHECKLIST** |
| 16. 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 | [ ]  |  |  |  |  |
| [ ]  | 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 behavior support plan | [ ]  |
|  |  |  |  |  |  |
|  |  |  | [ ]  | 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 | [ ]  |  |  |       |  |
|  |  |  |  |  |  |  |
| 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 IRIS consultant agency  |
|  | [ ]  | A. Child Protective Services | [ ]  | H. Physician |
|  | [ ]  | B1. Adult Protective Services | [ ]  | I. Provider Agency |
|  | [ ]  | B2. Wisconsin Incident Tracking Report Submitted | [ ]  | J. DHS Waiver Manager / Central Office |
|  | [ ]  | C. CSS / Children’s Services Specialist (Required for CLTS Waiver) | [ ]  | K. Caregiver Misconduct Statewide Complaint Hotline: 800-642-6552 |
|  | [ ]  | D. IRIS Independent Consultant | [ ]  | L. Other—Specify:  |
|  | [ ]  | E. Parent / Guardian (Required) | [ ]  | M. Note any person / entity **NOT notified** and why:       |
|  | [ ]  | F. Law Enforcement Agency |  |  |
|  | [ ]  | G. Licensing Agency |  |
|  |
| 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 IRIS consultant 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 CPS
7. [ ]  Report to APS
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**  |
| 29. Date Form Completed       | 30. Name – Primary IRIS Consultant.        |
| 31. Date of initial notification        |
| 32. Original Reporter:[ ]  Participant [ ]  Guardian (Can check other choices if this choice is checked)[ ]  Parent [ ]  Other Family Member[ ] [ ]  Staff in Provider Agency [ ]  Staff in other Provider Agency[ ] [ ]  Support and Service Coordinator / Broker [ ]  IRIS Consultant (IRIS only)[ ]  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** |
| 33. Name – Last       | Name – First      |
| 34. Title       | Name of Agency      |
| 35. Email Address       | 36. Telephone Number       |
| **SUPPORT & SERVICE COORDINATOR / INDEPENDENT CONSULTANT / BROKER INFORMATION (If different from above)** |
| 37. Name – Last       | Name – First      | 38 Telephone Number       |
| 39. Email address       |
|  |
|  |  |  |       |  |  |
|  | **SIGNATURE** – Person Reporting |  | **PRINT** Name |  | Date Signed |