

DEPARTMENT OF HEALTH SERVICESDivision of Long Term Care
F-22541 (05/2009)**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. Please consult the instructions in the Waiver manual for information about notification requirements and report deadlines. **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.**

PARTICIPANT INFORMATION

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

NOTIFICATION OF INCIDENT

11. Date Form Completed		12. Name - Primary Children's Services Specialist, Community Integration Specialist or person's chosen Independent Consultant.	
13. Type of Report (check all that apply below) <input type="checkbox"/> Critical <input type="checkbox"/> Original <input type="checkbox"/> Update <input type="checkbox"/> Correction <input type="checkbox"/> Incident Review Completed and Closed		14. Date of initial notification	
15. 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: _____		
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:

PERSON COMPLETING FORM INFORMATION

18. Name - Last		Name - First	
19. Title			
20. Name of Agency			21. Telephone Number ()

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

22. Name – Last	Name - First	23 Telephone Number ()
24. E-Mail address		
25. Agency of Affiliation (If applicable):		

INCIDENT INFORMATION

26. Date of Event	27. Location Event Occurred (Street, City, State, Zip Code)
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28. 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. | |

29. Was the perpetrator or alleged perpetrator involved or alleged to have been involved in the incident a paid service provider for subject of incident or was he/she not compensated for providing services and supports?

-
- Paid provider
-
- Unpaid

30. Name – Caregiver involved when incident occurred.

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

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

OUTCOME AND CONCLUSION

33. 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.

34. 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.

35. Type of change made or action taken by County/Waiver Agency or contractor as a result of Incident (check all that apply)
- a. Nothing changed
 - b. Corrective action initiated
 - c. Terminate staff
 - d. Change in personnel working with the participant
 - e. Added staff coverage
 - f. Change agency that provides service
 - g. Change to Individualized Service Plan
 - h. Added new service
 - i. Reduced service
 - j. Terminated service
 - k. Increased amount and/or type of external monitoring of setting
 - l. Medically related consult
 - m. Behavioral consult
 - n. Staff providing training related to subject of incident
 - o. Refer to Licensing (Children's)
 - p. Refer to Licensing (Adult)
 - q. Report to CPS
 - r. Report to APS
 - s. Report/Refer to caregivers
 - t. Refer to Disability Rights Wisconsin
 - u. Refer to District Attorney/law enforcement agency
 - v. Other – Specify: _____

EVENT / ALLEGATION CHECKLIST

36. 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"/>		

IF THE PARTICIPANT DIED, COMPLETE THE FOLLOWING:

37. Date of Death _____ 38. Official cause of death as reported on the death certificate _____

CONTACT / SUPPLEMENTAL REPORTING CHECKLIST

39. Check all persons / agencies contacted by county waiver agency
- A. Child Protective Services
 - B1. Adult Protective Services
 - B2. Wisconsin Incident Tracking Report Submitted
 - C. CSS / Children's Services Specialist (Required for CLTS Waiver)
 - D. Community Integration Specialist / CIS (Required for CIP 1A / 1B)
 - E. IRIS Independent Consultant
 - F. Parent / Guardian (Required)
 - G. Law Enforcement Agency
 - H. Licensing Agency
 - I. Physician
 - J. Provider Agency
 - K. DHS Waiver Manager / Central Office
 - L. Caregiver Misconduct Statewide Complaint Hotline: 800-642-6552
 - M. Other—Specify: _____

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