

**Department of Health and Hospitals (DHH)
Home and Community Base Services (HCBS)
Critical Incident Report Instructions**

The Critical Incident Report form is to be completed when a critical incident is made known or discovered by a Direct Service Provider (DSP) concerning a HCBS participant.

Participant Identifying Information: To be completed by the DSP

- NameEnter the name of the participant (as written on the Medicaid/Social Security card).
- Address/City/StateEnter the address of the participant and the city and state in which the participant resides.
- Phone #Enter the telephone # of the participant.
- Parish and RegionEnter the parish and region in which the participant resides.
- DOB and Gender.....Enter the date of birth and gender of the participant.
- SSN #Enter the Social Security number of the participant.
- Legal Status.....Check the participant’s legal status.
- Name of Family/Legal GuardianEnter the name of the participant family or legal guardian and telephone number.
- Family/Legal Guardian AddressEnter the address of the participant family or legal guardian.
- Service TypeCheck the type of Waiver and services the participant is currently receiving.
- Institutional Transition.....Check whether the participant transitioned to the Waiver program from an institutional setting, and enter the type of institution from which the participant transitioned.
- Marital StatusCheck the participant’s marital status.
- RaceCheck the participant’s race.
- Living SituationCheck the participant’s living situation.
- Disability.....Check the participant’s disabilities (check all that apply).

Incident Category: To be completed by the DSP

- Child Abuse/Neglect PrimaryCheck if abuse or neglect involves biological parents, step parents, legal guardian/curator as the perpetrator or alleged accused. (Participant age 0-17 years)
- Child Abuse/Neglect Non-PrimaryCheck if abuse or neglect involves a DSP staff person, neighbor, others, etc. (Participant age 0-17 years)
- Elderly Abuse/NeglectCheck if abuse or neglect involves participant age 60 years or above.
- Major InjuryCheck if the incident involves a major injury to the participant.

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- Fall Check if the incident involves a fall by the participant.
- Major Illness Check if the incident involves a major illness of the participant.
- Death Check if the incident involves the death of a participant, regardless of cause.
- Major Medication Error Check if the incident involves a major medication error by staff, pharmacy, participant, or family member.
- Major Behavioral Incident Check if the participant is involved in the following major behavioral incidents: attempted suicide, suicidal threats, self endangerment, elopement/missing, self injury, property destruction, offensive sexual behavior, sexual aggression, and physical aggression.
- Involvement with Law Enforcement..... Check if the incident report involves the following types of involvement with law enforcement: participant was arrested, staff was arrested or staff was issued citation for moving violation (while participant was in vehicle).
- Use of Restraints Check if the incident involves the use of the following type of restraints: Behavioral/Personal, Behavioral/Mechanical, Behavioral/Chemical, Medical/Personal, Medical/Mechanical, Medical /Chemical.

Event Information: To be completed by the DSP

- Participant Name..... Enter the name of the participant involved in the incident.
- Social Security Number Enter the Social Security number of the participant.
- Date/Time Incident Occurred Enter the date and time the incident occurred.
- Date/Time Incident Discovered Enter the date and time the incident was discovered.
- Location of Incident..... Check the location of the incident.
- Date /Time of Notification..... Enter the dates and times that DSP notified EPS, C.P., APS and law enforcement.
- Type of Health Care Admission..... If applicable, check the type of health care admission. (Check all that apply.)
- Admission Date(s) Enter the date(s) of health care admission.
- Reporter Enter the name of the reporter of the incident and the reporter's relationship to the participant.
- Support Coordination Agency Enter the name of the support coordination agency which provided support coordination at the time of the incident.
- Support Coordinator (S.C.) Enter the name and telephone # of the participant's support coordinator at the time of the incident.
- Direct Service Provider (DSP)..... Enter the name and telephone # of the participant's DSP at the time of the incident.

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Critical Incident Description: To be completed by the DSP

- Participant Name.....Enter the name of the participant involved in the incident.
- Social Security NumberEnter the Social Security number of the participant.
- Place of occurrence and addressEnter the place and address where the incident occurred, and enter the date and time of occurrence.
- Name(s) of individuals with Participant at the time of the incident..... Enter the name(s), address, telephone #, name of agency and relationship if known of individual who was with participant at the time of the incident.
- Critical incident descriptionEnter all information which is pertinent to the incident, including who, what, when, where, and how etc. In addition, include the name of the law enforcement notified, as well as the address and contact person.
- Name of Direct Service ProviderEnter the name of the Direct Service Provider Agency
- Date/Time reported to S.C.Enter the date and time the incident was reported to the participant’s support coordinator.
- Report completed byEnter the name of the individual completing the report, including the telephone #, date and region.
- Supplemental page(s)..... Attach the **Supplemental Form** to continue Critical Incident Report Description. Each additional page **must** be signed and dated.

Direct Service Provider Follow-up

- Participant Name.....Enter the name of the participant involved in the incident.
- Social Security NumberEnter the Social Security number of the participant.
- Direct Service Provider Follow-upEnter all pertinent information related to the critical incident, including but not limited to the following: results of medical/dental appointments, lab work, discharge instructions from hospital or psychiatric facility, results of team meetings, revisions of Individual Service Plan (ISP) etc.
- Follow-up completed byEnter the name of the individual completing the follow-up, including the telephone #, date and region.
- Supplemental page(s)..... Attach the **Supplemental Form** to continue Critical Incident Report Follow-Up. Each additional page **must** be signed and dated.