Louisiana Department of Health
Office for Citizens with Developmental Disabilities (OCDD)
Home and Community Based Services (Waiver Services) Critical Incident Report Form

PARTICIPANT IDENTIFYING INFORMATION:

Name First:	**Name Middle (if known):**	**Name Last:**	
Address:	**City:**	**State:**	**Telephone #:**
Region:	**DOB:**	**SSN:**	
Parish:	**Gender:** ☐ **Male** ☐ **Female**		
Name of Family or Legal Guardian:		**Telephone of Family or Legal Guardian:**	

Incident Occurred Date:_____/Time:_____ ☐AM or ☐PM

Incident Discovered Date:_____/Time:_____ ☐AM or ☐PM	**Direct Service Provider Agency Name:**

(Shaded Area for Use of DSP supervisor only) **Service Type:** ☐ NOW- New Opportunities Waiver ☐ CC- Children's Choice Waiver ☐ SW- Supports Waiver ☐ ROW- Residential Options Waiver	**Living Situation:** ☐Alone ☐With Relative(s) ☐With Roommate(s) ☐With Spouse	**Legal Status:** ☐Competent Major ☐Interdicted ☐Emancipated ☐Minor ☐Continued Tutorship

Services at Time of Incident		
Waiver Services Scheduled ☐ No ☐ Yes	Waiver Services Present ☐ No ☐ Yes Name(s) of Employee(s):	Natural Supports Present: ☐ No ☐ Yes Name(s):

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Participant Name:	SSN:

INCIDENT CATEGORIES: Check those that apply

Note: All protective services allegations must be verbally reported

Note to Support Coordinator (SC): If the SC discovers/witnesses an Abuse, Neglect, Exploitation or Extortion incident involving a participant over the age of 18, the SC should immediately verbally report the incident to APS. The SC should complete the CIR and keep a copy for SCA record. Important: The SC shall not enter the information regarding APS Cases aged over 18 into the Incident System. This only applies to APS cases aged over 18.

APS Incident Type (Participants 18 years and older)	**Age 0-17 years:**	**CPS Confirmation:**	***For use LGE personnel only:***
☐Abuse ☐Neglect ☐Exploitation ☐Extortion ☐Self Neglect	**Child Abuse** ☐Primary ☐Non Primary **Child Neglect** ☐Primary ☐Non Primary	**ID of CPS Intake Worker:** _____	**EPS Incident Type** **(Participants 60 years and older):** ☐Abuse ☐Neglect ☐Exploitation ☐Extortion ☐Self Neglect

☐**Major Injury**	☐**Fall**	☐**Death**	☐**Loss or Destruction of Home**

☐**Major Illness** *Also - check if Sub Category applies:* ☐ Decubitis ☐ Seizure ☐ Pneumonia ☐ Bowel Obstruction	☐**Major Behavioral Incident:** ☐Attempted Suicide ☐Suicidal Threats ☐Self- Endangerment ☐Elopement/Missing ☐Self-Injury ☐Offensive Sexual Behavior ☐Sexual Aggression ☐Physical Aggression ☐Property Destruction	☐**Major Medication Incident** ☐Pharmacy Error ☐Staff Error ☐Family Error ☐Participant Error **Restraints Use:** ☐BEHAVIORAL ☐Personal ☐Mechanical ☐Chemical ☐MEDICAL ☐Personal ☐Mechanical ☐Chemical	**Involvement with Law Enforcement:** ☐Participant arrested ☐Participant is a victim of a crime

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Participant Name:	**SSN:**

EVENT INFORMATION

(THIS SPACE IS NOT FOR INCIDENT INFORMATION)	**Location of incident:** ☐Home ☐Community ☐Facility ☐Vehicle ☐Day Program

☐ **DSP notified APS/EPS** Date:_____/Time:_____ ☐AM or ☐PM
☐ **DSP notified Law Enforcement** Date:_____/Time:_____ ☐AM or ☐PM
☐ **DSP notified C.P.** Date:_____/Time:_____ ☐AM or ☐PM

Type of Health Care Admissions and Date of Admissions (check all that apply):

☐Emergency Room	Date:_____	☐ Nursing Home	Date:_____
☐Acute Care Hospital	Date:_____	☐ Respite Center	Date:_____
☐Psychiatric Hospital	Date:_____		

Reporter Name:

Relationship:

☐APS	☐Parent	☐OAAS	☐School
☐Child	☐Guardian (child)	☐OCDD Waiver office	☐Self
☐Child Protection	☐Home Health	☐Other	☐Sibling
☐Curator (adult)	☐Hospital	☐Guardian	☐Spouse
☐Day Program	☐HSS	☐Physician/Nurse	☐Support Coordinator
☐Direct Service Worker	☐Law Enforcement	☐Provider	☐Under Curator
☐DCFS			

Support Coordination Agency:	**Agency Telephone #:**
Support Coordinator (SC) Name	**SC Telephone #:**
Direct Service Provider:	**DSP Telephone #:**

HCBS Critical Incident Report Form

Participant Name:	**SSN:**

Critical Incident Description:

Enter all information regarding the incident (i.e., who, what, when, where, how). Use as many pages as necessary, numbering, dating and signing each page. Include the name of the individual with the participant at the time of the incident (including relationship, telephone #). If law enforcement was notified, include the name of the agency, conta person, and address. (Character Limit: 1,000)

Name of Direct Service Provider:	**Date reported to SC:**	**Time:**

Report completed by:	**Telephone #:**	**Date:**	**Region**

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Critical Incident Report Description – DSP Follow-Up

Use as many copies of this form as needed to complete your report. Each additional page must be signed and dated

Participant Name:	**SSN:**

If participant was released from a facility or outpatient procedure, indicate date and time of release:

Date:_____/Time:_____ ☐AM or ☐PM

FOR SC USE ONLY: *Meets criteria for Major Medical Event/major illness:* ☐Yes or ☐No

Direct Service Provider Follow-up

Follow-up admission and date **after** initial health care contact (if applicable):

☐Acute Care Hospital	Date:_____	☐Respite Center	Date:_____
☐Psychiatric Hospital	Date:_____	☐Pinecrest SSC	Date:_____
☐Rehabilitation Facility	Date:_____	☐Hospice: center-based	Date:_____
☐Nursing Home	Date:_____		

Enter any follow-up related to remediating the critical incident such as modifications to environment, outcome of health care appointments, labs, discharge instructions from hospital, change in staffing, medications, treatments, team meetings, or revisions to Plan of Care.

Name of Direct Service Provider:	**Date reported to SC:**	**Time:**	
Follow-up completed by:	**Telephone #:**	**Date:**	**Region**

Attach **Supplemental Form** to continue Critical Incident Report Description as necessary. Each additional page **must** be signed and dated.

Additional space for incident description and follow-up.