

Reportable Event (RE) Form – RE Number:

☐ **MDCSW** – Send to DHMH ☐ **LAH** – Send to DHMH ☐ **Older Adults** – Send to MDoA
☐ **RTC** – Send to DHMH ☐ **Autism** – Send to MSDE ☐ **Model** – Send to DHMH

REPORTING INFORMATION (Check/enter all that apply)**Initial Telephone Report:** ☐ CM ☐ OSA ☐ OHS ☐ PROVIDER**Date/Time of Telephone Report:** /**Name of Reporter:****Title/Agency** (if applicable):**Relationship to Participant/Applicant:****Phone:** ext.**Email Address:****Person Completing the Form:****Date Form Completed and sent to CM:****Name** (If different from reporter):**Title/Agency** (if applicable):**Relationship to Participant/Applicant:****Phone:** ext.**Email Address:****EVENT INFORMATION** (Check/enter all that apply)**Event Date/Time:** /**Event Type:** ☐ Incident ☐ Complaint ☐ Both**Participant/Applicant Name:****Address:****City/State/Zip:****Enter MA#:****DOB:** **Gender:** ☐ M ☐ F**CM Name:****Provider Information (If involved or present):****Provider#:** **Provider Type:****Agency/ALF Name** (if applicable):**Contact Person:****Phone:** ext.**Date of Service Interruption** (if applicable): **Start:** **End:****ALLEGED INCIDENT(S)** (Check/enter all that apply)**Abuse:** ☐ Physical ☐ Sexual ☐ Verbal ☐ Emotional **Neglect:** ☐ Nutrition ☐ Medical ☐ Self ☐ Environment**Accident/Injury** (Requiring Treatment beyond First Aid): ☐ Fall ☐ Fracture ☐ Burn ☐ Laceration/Wound ☐ Other**Emergency Room Visit:** ☐ **Hospitalization:** ☐ **In-Patient Psychiatric Hospitalization:** ☐ **Death:** ☐ **Suicide:** ☐ **Suicide Attempt:** ☐**Abandonment:** ☐ **Elopement/Missing Person:** ☐ **Exploitation:** ☐ Financial / Theft **Rights Violation:** ☐**Seclusion/Restraint:** ☐ Physical ☐ Chemical ☐ Involuntary Seclusion**Treatment Error:** ☐ Medication ☐ Other Treatment Error:**Other Incident Type:** ☐**COMPLAINT** (Check/enter all that apply)**Quality of Care/Service Issue:** ☐ **Other:** ☐**Phone:** ext.**Email Address:****Name of Complainant:****Address:****City/State/Zip:*****Explain dissatisfaction with any aspect of the program's operations, activities, or administration under the Description of Event section on pg. 2.***

Medicaid Home and Community-Based Services
Reportable Event (RE) Form

Participant/Applicant Name:

Event Date:

DESCRIPTION OF EVENT AND RESPONSE

This section must be completed by the Provider/Participant/Family/Other and should include a description of the incident and/or complaint (event) and what actions were taken to appropriately respond to the event. If applicable, complete Contact Information page

SUBMIT WRITTEN RE FORM TO THE CM WITHIN REQUIRED TIMEFRAMES: 7 DAYS OF THE EVENT DATE.

THE DESCRIPTION SHOULD INCLUDE THE FOLLOWING INFORMATION:

Immediate actions taken to safeguard the participant;

Names and title(s) of individual(s) present at time of event;

Diagnosis: (For ER visits or hospitalizations);

Current status of the participant prior to submission of this report to the CM;

Any other important information that fully describes the event

Is other documentation attached? (e.g. discharge summary, ALF incident report, additional handwritten pages): ☐ **Yes** ☐ **No**

DESCRIPTION OF EVENT (Handwritten entries must be printed and legible):

Appendix C**Medicaid Home and Community-Based Services**
Reportable Event (RE) Form**Participant/Applicant Name:****Case Manager/Service Coordinator:****Event Date:****CONTACT INFORMATION****This section must be completed. All applicable agencies or individuals should be contacted.**

Select all agencies/individuals contacted	Contact Name	Date	Telephone #	Email	Address
☐ Case Manager					
☐ OSA					
☐ Law Enforcement Agency					
☐ Adult (APS) or Child Protective Services (CPS) * (APS or CPS MUST be contacted for all alleged abuse, neglect or exploitation events.)					
☐ Office of Health Care Quality					
☐ Authorized Guardian/Representative/Family *Participant Authorized Release ☐ YES ☐ NO Date of Release:					
☐ Ombudsman Program					
☐ Local School System					
☐ Other:					

Comments:

Medicaid Home and Community-Based Services
Reportable Event (RE) Form

Participant/Applicant Name:

Event Date:

CM/OSA INTERVENTION AND ACTION PLAN(S)

This section must be completed by the CM/OSA. A copy of the RE form must be maintained in the participant/applicant file and a copy must be sent to the OSA, if applicable.

SUBMIT COMPLETED RE FORM TO THE OSA WITHIN REQUIRED TIMEFRAMES: 7 DAYS FROM THE EVENT DATE.

RESPOND TO ALL APPLICABLE QUESTIONS:

The provider/participant/family/other responded to the event appropriately? ☐ Yes ☐ No ☐ N/A

The provider/participant/family/other contacted APS/CPS if the event was abuse, neglect, or exploitation? ☐ Yes ☐ No ☐ N/A

The provider contacted the guardian/representative? ☐ Yes ☐ No ☐ N/A

The participant was provided with their right to appeal for an adverse action (e.g. denial or reduction of services)? ☐ Yes ☐ No ☐ N/A

Describe Findings, Interventions, Follow-up, and Corrective Action Plan(s):

To be completed by OSA only

Date Report received:

OSA Review Needed: ☐ Yes ☐ No **OSA Staff Assigned:**

Assignment Date:

Review Due Date:

Case Closure date:

Status Letter Date (if applicable):