

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

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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
<input type="checkbox"/> Case Manager					
<input type="checkbox"/> OSA					
<input type="checkbox"/> Law Enforcement Agency					
<input type="checkbox"/> Adult (APS) or Child Protective Services (CPS) * (APS or CPS MUST be contacted for all alleged abuse, neglect or exploitation events.)					
<input type="checkbox"/> Office of Health Care Quality					
<input type="checkbox"/> Authorized Guardian/Representative/Family *Participant Authorized Release <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Release:					
<input type="checkbox"/> Ombudsman Program					
<input type="checkbox"/> Local School System					
<input type="checkbox"/> Other:					

Comments:

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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):