Medicaid Home and Community – Based Services
Reportable Event Form

Instructions for Completing Reportable Event Form

1. NAME and DATE

A. Enter the name of the participant or applicant in the upper left hand corner of pages one and two.
B. Enter the date of the alleged incident or complaint in the upper left hand corner of pages one and two.

2. JURISDICTION

Enter the jurisdiction of the applicant or participant involved in the alleged incident or complaint in the upper left hand corner of page one.

3. WAIVER PROGRAM

Select the appropriate waiver program for the applicant or participant involved in the alleged incident or complaint.

A. Autism
B. Living at Home
C. Older Adult

4. **REPORTING INFORMATION**

A. Report date and time:
Enter the date and time you are reporting the event
B. Reported by:
Enter the name of the person reporting the alleged incident or complaint.
C. Reported to:
Check the entity the alleged incident or complaint was reported to.
CM/SC - Case Manager/Service Coordinator
ASA - Administrating State Agency
D. Person completing form:
   a. Check the box that shows your relationship to the applicant or participant involved in the alleged incident or complaint.
   b. Name: Enter your name
   c. Telephone Number: Enter your telephone number
   d. Email Address: Enter your email address (if applicable)

5. EVENT INFORMATION

A. Date and Time: Enter the date and time of the alleged incident or complaint
B. Event Involved: Check who the event involved
   a. Applicant – is a person applying to a waiver program
   b. Participant – is a person enrolled in a waiver program
C. Name: Enter the name of the applicant or participant
D. Address: Enter the address of the applicant or participant
E. City/State/Zip: Enter the city, state and zip code for the applicant or participant
F. DOB: Enter the date of birth for the applicant or participant
G. MA #: Enter the Medical Assistance number of the applicant or participant (if known or available)

H. SS #: Enter the Social Security number of the applicant or participant (if known or available)
I. Staff Involved (if applicable): Enter the name of staff person involved
If no staff member is involved please skip to letter O
J. Provider: Enter provider type
Agency – someone who is employed by a company
Independent – someone who works for his/her self; does not work for an agency
K. Provider #: Enter the provider number
L. Provider/Facility: Enter the name of the provider or agency involved in the alleged incident or complaint
M. Contact: Enter the name of the contact person, if different from the Provider/Facility listed above.
N. Phone: Enter the phone number of the contact person
O. Service Interruption (if applicable): Enter the start date, end date and reason that services were stopped

COMPLAINT

6. Check all complaint types whether quality of care or administrative service issues that apply to this alleged event.
   A. Access
   B. Communication
   C. Delays
   D. Professionalism
   E. Other

7. COMPLAINANT INFORMATION

Enter the following information regarding the person making the complaint:
A. Name
B. Address
C. City, State and Zip Code
D. Email Address

8. ALLEGED INCIDENT(S)

Check all incident types that apply to this alleged incident or complaint.
A. Abuse (Physical, Sexual, Verbal or Emotional)
B. Neglect (Nutritional, Medical, Self or Environment)
C. Exploitation (Financial, Theft or Destruction of Property)
D. Accident/Injury (Requiring treatment beyond First Aid)
E. Death (Anticipated or Unanticipated and Enter Date of Death)
F. Hospitalization (Anticipated, Unanticipated, In – patient psychiatric or Emergency Room Visit
G. Restraint (Physical, Chemical or Seclusion)
H. Treatment Error (Medication, Delegated Task or Other)
I. Missing Person
J. Abandonment
K. Rights Violation
L. Other

9. EVENT DESCRIPTION and RESPONSE

Enter specific details regarding incident or complaint.
A. Parties Involved – List all people involved

B. Location – where did the alleged incident and/or complaint occur?
C. Injuries of person(s) involved (if applicable)
D. What actions led up to the event, if known?
E. What actions were taken during and after the event?

10. CONTACT INFORMATION

Check the box of the entity(ies) or person(s) contacted in regards to this alleged incident or complaint. Enter the requested information for the entity contacted about this alleged incident or complaint.

A. For **Adult Protective Services** and/or **Child Protective Services** and/or **Law Enforcement Agency** and/or **Office of Health Care Quality** and/or **Ombudsman Program/Local School System** and/or **Other** enter the following:
   a. Date Contacted – Date of contact
   b. Person Contacted – Name of person communicated with
   c. Telephone Number – Phone number for person communicated with
   d. Comments – Additional information regarding contact with this entity or person

B. Authorized Guardian/Representative/Parent (if applicable)
   IMPORTANT NOTE: This applies to the Living at Home and Older Adults Waiver Program Only. DO NOT CONTACT THE AUTHORIZED GUARDIAN or REPRESENTATIVE or PARENT UNLESS THE PARTICIPANT OR APPLICANT HAS AUTHORIZED RELEASE OF INFORMATION
   a. Name: Enter the name of the authorized guardian or representative or parent.
   b. Address: Enter the address of the authorized guardian or representative or parent.
   c. City/State/ZIP: Enter the city, state and zip code for the authorized guardian or representative or parent.
   d. Telephone Number: Enter the phone number for the authorized guardian or representative or parent.
   e. **Participant authorized release of information**: Did the participant authorize release of information regarding the alleged incident or complaint? Please check the appropriate box yes or no.
   f. Date contacted: Date of contact with authorized guardian or representative or parent.
   g. Comments: Additional information regarding your contact with the authorized guardian or representative or parent.

11. MAILING REPORTABLE EVENT PROCEDURE

A. Please mail the completed reportable event form to the appropriate service coordination or case management entity. To obtain contact information for service coordinators or case managers by program please select from the list below.
   a. Autism
   b. Living at Home
   c. Older Adult