ENCOMPASS HEALTH HOME

INCIDENT REPORT FORM

Care Management Agency:	

DATE OF LAST CONTACT PRIOR TO INCIDENT								
DATE AND TIME OF INCIDENT:			☐	AM	☐	PM	**DATE OF REPORT:**	
DATE AND TIME OF DISCOVERY:			☐	AM	☐	PM		
CURRENT LOCATION:								

DATABASE INFORMATION

Participant Name:		DOB:		Enrollment Date:		CIN#:	
Diagnosis:							
Medication(s):							
Participant #2 Name: (If applicable)		DOB:		Enrollment date:			

INCIDENT CATEGORIES

Allegations of Abuse: **(are Reportable to Justice Center if a Licensed Program is involved)**		**Other Types of Incidents:**			
☐	* Physical Abuse	☐	*Death (Unexpected/Unexplained)	☐	*Missing Person
☐	*Psychological Abuse	☐	*Crime Level 1	☐	*Missing AOT
☐	*Sexual Abuse	☐	*Violation of Protected Health Information	☐	*Other Incident w/Actual/Potential Adverse Effect on Life, Health, Welfare or Safety (Define):
☐	*Neglect	☐	*Suicide Attempt		
☐	*Misappropriation of Funds				***Requires NYSDOH Notification**

INCIDENT INFORMATION

DESCRIBE INCIDENT: Specify Who, What, When, Where, Why;
Include: **1**.Information regarding events that occurred prior to incident **2**. Description of most recent contacts with Care Manager
3.Preliminary Investigation Findings
If additional space is needed, please attach separate page

Immediate Participant interventions/ protections performed by Care Manager/CMA, including how immediate needs were met:

Date of Incident: _____ Client Name:_ _____

NOTIFICATIONS:

Notified Party	Date/Time	Notified by Whom/Name of Contact/Description
Health Home		
NYS Department of Health		
Other Licensed Agency:		
Justice Center–VCPR		
Other State Agency:		
Child Protective Services/NYS Central Register of Child Abuse		
Adult Protective Services		
Family/Guardian/Other Qualified Persons		
Managed Care Plan:		
Law Enforcement		
Parole/ Probation		
Mental Hygiene Legal Services		
Coroner/Medical Examiner		
Other Provider -		
Other -		
Other -		

Physician Notified Date:		Physician Notified Time:		AM	☐	PM	☐

Signature of Person Reporting Incident:		**Date:**	
Supervisor/Manager Signature:		**Date:**	

HEALTH HOME REVIEW

Date Received:					
☐	**Reportable to JC**	☐	**Reportable to DOH**	**Date Investigation Determined/Assigned:**	
Investigation Assigned to:					
Investigators:					
☐	**Health Home**				
☐	**Care Management Agency**				
☐	**Investigation to be completed by Other Licensed Agency:**				

Date Investigation Completed:		**Appropriate Procedures Followed?** ☐	
Follow Up/Corrective Action Recommended (See Below)			
Health Home Signature:		**Date:**	