Department of Health and Hospitals
Office of Aging and Adult Services (OAAS)
Home and Community Based Services (HCBS) 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/Legal Guardian:		**Telephone of Family/Legal Guardian:**	
Family/Legal Guardian Address:			

Service Type:	**Marital Status**	**Race:**	**Living Situation:**	**Legal Status:**
☐ CCW ☐ ADHC	☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	☐African American ☐White ☐Hispanic ☐Asian/Pacific Islande ☐American Indian ☐Alaskan ☐Unknown/Other	☐With Relatives ☐With Other/Unknov ☐Alone ☐With Roommate ☐With Spouse ☐With Shared Suppo ☐In Licensed Facility ☐In Unlicensed Facilit ☐Homeless	☐Competent Major ☐Interdicted ☐Emancipated ☐Minor ☐Continued Tutorship

Disability: Person having			**Institutional Transition:**
			☐ Yes ☐ No
☐ Autism ☐ Brain/Head Injury ☐ Cerebral Palsy ☐ Dementia ☐ Disease-Related ☐ Epilepsy ☐ Hearing Impairment	☐Mental Illness ☐ MR Mild ☐ MR Moderate ☐MR Profound ☐MR Severe ☐Paraplegia ☐Stroke	☐Speech Dysfunction ☐Quadriplegia ☐Substance Abuse ☐Visual Impairment ☐None Determinable ☐Other Physical Disability ☐Other Developmental Disabil	**Type:** ☐Nursing Facility ☐SSC (DC) ☐ICF/DD (Private)

Department of Health and Hospitals
Office of Aging and Adult Services (OAAS)
Home and Community Based Services (HCBS) Critical Incident Report Form

Participant Name:	**SSN:**

INCIDENT CATEGORIES: Check only 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 between the ages of 18 -59, the SC should immediately verbally report the incident to APS. The SC should complete the CIR and keep a copy for his/her record. Important: The SC shall not enter the information regarding APS Cases aged 18-59 into the Online Tracking Incident System. This only applies to APS cases aged 18-59, not APS cases aged 60 and above.

APS Incident Type (Participants 18 years and older)

- ☐ Abuse
- ☐ Neglect
- ☐ Exploitation
- ☐ Extortion
- ☐ Self Neglect

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

☐ **Major Medical Event**	☐ **Major Behavioral Incident:**	☐ **Major Medication Incident**	**Involvement with Law Enforcement:**
	• Attempted Suicide • Suicidal Threats • Self- Endangerment • Elopement/Missing • Self-Injury • Offensive Sexual Behavior • Sexual Aggression • Physical Aggression	• Pharmacy Error • Staff Error • Family Error • Participant Error	☐ Participant arrested ☐ Participant is a victim of a crime

Department of Health and Hospitals
Office of Aging and Adult Services (OAAS)
Home and Community Based Services (HCBS) Critical Incident Report Form

Participant Name:	**SSN:**

EVENT INFORMATION

Incident Occurred Date:_____/Time:_____ ☐AM or ☐PM **Incident discovered** Date:_____/Time:_____ ☐AM or ☐PM	**Location of incident:** ☐Home ☐Community ☐Facility ☐Vehicle ☐Day Program

☐ **DSP notified APS** Date:_____/Time:_____ ☐AM or ☐PM
☐ **DSP notified Law Enforcement** Date:_____/Time:_____ ☐AM or ☐PM

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

☐Psychiatric Hospital	Date:_____	☐Acute Care Hospital	Date:_____
☐Rehabilitation Facility	Date:_____	☐Respite Center	Date:_____
☐Emergency Room	Date:_____	☐SS (Developmental Center)	Date:_____
☐Nursing Home	Date:_____	☐Hospice	Date:_____

Reporter Name:

Relationship:

☐APS	☐Friend/Neighbor	☐OAAS	☐Supervisor
☐Child	☐Guardian	☐OBH	☐Self
☐Child Protection	☐Home Health	☐OPH	☐Sibling
☐Curator	☐Hospital	☐Other	☐Spouse
☐Day Program	☐HSS	☐Parent	☐Support Coordinat
☐Direct Service Worker	☐Law Enforcement	☐Physician	☐Under Curator
☐DSS		☐Provider	

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, et cetera). Include all specifics and details related to the incident. Include the name of the individual with the participant at the time of the incident (including relationship, address, telephone # and name of agency et cetera). Use as many pages as necessary, numbering, dating and signing each page. (If Law Enforcement was notified, include the name of the agency, contact person, and address.)

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

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

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:* ☐Yes or ☐No

Direct Service Provider Follow-up

Enter any follow-up related to the critical incident: results of medical/dental appointments, labs, discharge instructions from hospital, change in staffing, medications, treatments, modifications to behavior support plan, tea meetings, revision to ISP, etc.

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