DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Long Term Care
F-22541 (08/2015)

INCIDENT REPORT - MEDICAID WAIVER PROGRAMS

INSTRUCTIONS: This form may be completed by section as instructed; however, when the form is final it must be completed in its entirety. Reporting requirements are applicable to all participants receiving services through CIP 1A/1B, CIP II/COP-W Medicaid Waiver Programs. Additional information may be attached to supplement, but not replace, information provided on the report form. **For CIP 1A/1B**, this form is to be submitted to: DHSCBIR@dhs.wisconsin.gov or fax to **DHSCBIR** at 608-261-6752. Send a copy to the Area Quality Specialist. **For CIP II/COP-W**, this form is to be sent to The Management Group at WaiverQualitySupport@tmgwisconsin.com or send by fax to 866-505-1316.

TIMELINES: Waiver Agencies must submit initial incident reports to BMC within **THREE BUSINESS DAYS** of the initial notification. For additional requirements, see the Incident Reporting Instructions (F-22541i)

Completion of this form meets the requirements of the state's CMS-approved 1915c Medicaid Waiver Programs.

Today's Date	Medicaid Waiver Program ☐ CIP 1A ☐ CIP 1B ☐ CIP II ☐ COP-W

PARTICIPANT INFORMATION (Last Name, First Name, M.I.)

Address Street (Participant)	City/State/Zip Code
Date of Birth	Telephone Number
Provider Agency Name	Provider Agency Address
Waiver Agency Incident Reporting Lead Staff	Guardian/Primary Contact: (Name, Phone Number, Email)

NOTIFICATION DATE (Date Waiver Agency Notified of Actual/Alleged Event)

INCIDENT REPORTER INFORMATION (Last Name, First Name, Title)

Agency	Phone	Email

Is the reporter the primary Care Manager? ☐ Yes ☐ No

INCIDENT INFORMATION

Date of Incident	Location of Incident (City, State, Zip Code)
Alleged Perpetrator Name (Last Name, First Name)	Relationship to Participant (e.g., caregiver, spouse)

Type of Report
☐ Original ☐ Update ☐ Incident Review Completed and Closed

Setting Where Incident is Believed/Alleged to Have Occurred:

- ☐ Person's Own Home/Apt.
- ☐ Adult Family Home 1-2 Bed
- ☐ Adult Family Home 3-4 Bed
- ☐ CBRF
- ☐ RCAC
- ☐ Work Site in Community
- ☐ Work Site-Congregate Vocational Provider
- ☐ Day Care/Day Services Facility
- ☐ Community Setting (park, store, mall, etc.)
- ☐ Respite Provider Site
- ☐ Another Private Residence
- ☐ Waiver Transportation Provider-public
- ☐ Waiver Transportation Provider Agency or Individual
- ☐ Public Transportation Provider-not program funded
- ☐ Not Known/Undetermined
- ☐ Other (Specify):

EVENT/ALLEGATION CHECKLIST
Check applicable event type(s)/allegations below: Check "Alleged Only" if there is uncertainty whether the event occurred.
If unsure as to incident type, consult the definitions in the instructions (Form F-22541i)

Event Type/Allegation	**Alleged Only** ☐	**Event Type/Allegation**	**Alleged Only** ☐
Abuse ☐ Mental/Emotional ☐ Physical ☐ Sexual ☐ Verbal ☐ Financial Exploitation (Misappropriation of the person's funds or property, identity theft)		Neglect (Caregiver/other responsible individual) ☐ Environmental Safety ☐ Failure to follow service/treatment plan ☐ Failure to seek medical care/treatment ☐ Failure to provide basic nutrition/special diet ☐ Other (specify): Neglect (Self) ☐ Environmental Safety ☐ Failure to manage self-care/health condition ☐ Nutrition, diet ☐ Other (Specify):	
RESTRAINT ☐ Unauthorized use of Restraint ☐ Unreasonable Confinement/Seclusion ☐ Other Restraint Related Incident (e.g., injury)		DEATH ☐ Anticipated Date: ☐ Unanticipated ☐ Unexplained	

Description of Incident/Initial Report: Include **perpetrator** if known/alleged. If **death** occurred, include cause of death)

Describe action taken to resolve incident and assure the participant's health, safety, and continued community presence

OUTCOME AND CONCLUSION
What is the **current status** of the waiver participant? As a result of the incident, were there any **changes** to his/her Individual Service Plan, service provider or staff, living arrangement, work, guardian, etc.?

Describe how these changes assure the participant's health and safety and improve his/her quality of life.

CONTACT/SUPPLEMENTAL REPORTING CHECKLIST: Check all persons/agencies contacted by the Waiver Agency

☐ Adult Protective Services
☐ Area Quality
☐ Law Enforcement Agency
☐ Licensing Agency (DQA)
☐ Certification Agency (County, Nonprofit, etc.)
☐ Physician
☐ Provider Agency
☐ Caregiver Misconduct
☐ DHS/DLTC
☐ Other(s) Contacted (Specify):

PERSON COMPLETING FORM INFORMATION

Last Name	First Name
Title	Name of Agency
Email Address	Phone Number

SUPPORT AND SERVICE COORDINATOR/CARE MANAGER/BROKER INFORMATION (If different from above)

Last Name	First Name	Telephone Number
Agency of Affiliation (if applicable)		Email Address

☐ By submitting this report to DHS, I affirm that the information provided is an accurate reflection of the reported incident, and I have not knowingly withheld any information regarding this incident.

☐ County Waiver Agency has reviewed this Incident Report.