Department of Health and Hospitals
Office for Citizens with Developmental Disabilities
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/Guardian:

Family/Legal Guardian Address

Service Type:	**Marital Status**	**Race**	**Living Situation**	**Legal Status:**
☐ NOW ☐ CC ☐ SW ☐ ROW ☐ State Funded	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ African American ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian ☐ Alaskan ☐ Unknown/Other	☐ With Relatives ☐ With Other/Unknown ☐ Alone ☐ With Roommate ☐ With Spouse ☐ With Shared Supports ☐ In Licensed Facility ☐ In Unlicensed Facility ☐ Homeless	☐ Competent Major ☐ Interdicted ☐ Emancipated ☐ Minor ☐ Continued Tutorship

Disability: **Person having**			**Institutional Transition** ☐ Yes ☐ No **Type:**
☐ 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 ☐ Other Developmental Disability	☐ Nursing Facility ☐ SSC (DC) ☐ ICF/DD (Private)

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Participant Name:	**SSN:**

INCIDENT CATEGORIES: Check only those that apply

Note: All protective services allegations must be verbally reported

Child Abuse
- ☐ Primary
- ☐ Non Primary

Child Neglect
- ☐ Primary
- ☐ Non Primary

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

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

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

☐ **Major Illness**

Check if Sub Category applies:
- ☐ Decubitis
- ☐ Seizure
- ☐ Pneumonia
- ☐ Bowel Obstruction

Major Behavioral Incident
- ☐ Attempted suicide
- ☐ Suicidal threats
- ☐ Self Endangerment
- ☐ Elopement/ missing
- ☐ Self injury
- ☐ Property destruction
- ☐ Offensive Sexual Behavior
- ☐ Sexual Aggression
- ☐ Physical Aggression

Major Medication Incident
- ☐ Pharmacy Error
- ☐ Staff Error
- ☐ Family Error
- ☐ Participant Error
- ☐ Non Adherence

Involvement with Law Enforcement
- ☐ Participant arrested
- ☐ Staff arrested
- ☐ Staff issued a Citation for Moving Violation (while participant is in vehicle)
- ☐ Participant is a victim of a crime

Restraints Use:

BEHAVIORAL
- ☐ Personal
- ☐ Mechanical
- ☐ Chemical

MEDICAL
- ☐ Personal
- ☐ Mechanical
- ☐ Chemical

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EVENT INFORMATION

Incident occurred Date:_____ /Time: _____ ☐AM or ☐PM

Incident discovered Date:_____ /Time: _____ ☐AM or ☐PM

Location of Incident:

☐Home ☐ Vehicle
☐Community ☐Day Program
☐Facility

☐ **DSP notified EPS** Date: _____ /Time: _____☐AM or ☐PM

☐ **DSP notified C.P**. Date: _____ /Time: _____☐AM or ☐PM

☐ **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
☐Child
☐Child Protection
☐Curator
☐Day Program
☐Direct Service Worker
☐DSS
☐EPS
☐Friend/Neighbor
☐Guardian
☐Home Health
☐Hospital
☐HSS
☐Law Enforcement
☐OAD
☐OMH
☐OPH
☐Other
☐Parent
☐Physician
☐Provider
☐Supervisor
☐Self
☐Sibling
☐Spouse
☐Support Coordinator
☐Under Curator

Support Coordination Agency:	**Agency Telephone #:**
Support Coordinator (SC) Name:	**SC Telephone**

Direct Service Provider:	**DSP Telephone #:**

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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 individuals 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:

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Attach **Supplemental Form** to continue
Critical Incident Report Description as necessary.
Each additional page **must** be signed and dated.

Participant Name:	**SSN:**

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, team meetings, revision to ISP, etc.

Follow-up completed by:	**Telephone #:**	**Date:**	**Region:**

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Continue HCBS Critical Incident Report Form

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 into the OCDD-approved data system.** This only applies to **APS cases, not EPS or CP.**

Attach **Supplemental Form Appendix C** to continue Critical Incident Report Follow-up.
Each additional page **must** be signed and dated.