

**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:**

<b>Name First:</b>		<b>Name Middle (if known):</b>		<b>Name Last:</b>	
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Telephone #:</b>	
<b>Region:</b>		<b>DOB:</b>	<b>SSN:</b>		
<b>Parish:</b>		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>Name of Family/Legal Guardian:</b>			<b>Telephone of Family/Legal Guardian:</b>		
<b>Family/Legal Guardian Address:</b>					
<b>Service Type:</b>	<b>Marital Status</b>	<b>Race:</b>	<b>Living Situation:</b>	<b>Legal Status:</b>	
<input type="checkbox"/> CCW <input type="checkbox"/> ADHC	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan <input type="checkbox"/> Unknown/Other	<input type="checkbox"/> With Relatives <input type="checkbox"/> With Other/Unknown <input type="checkbox"/> Alone <input type="checkbox"/> With Roommate <input type="checkbox"/> With Spouse <input type="checkbox"/> With Shared Support <input type="checkbox"/> In Licensed Facility <input type="checkbox"/> In Unlicensed Facility <input type="checkbox"/> Homeless	<input type="checkbox"/> Competent Major <input type="checkbox"/> Interdicted <input type="checkbox"/> Emancipated <input type="checkbox"/> Minor <input type="checkbox"/> Continued Tutorship	
<b>Disability: Person having</b>				<b>Institutional Transition:</b>	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Autism <input type="checkbox"/> Brain/Head Injury <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Dementia <input type="checkbox"/> Disease-Related <input type="checkbox"/> Epilepsy <input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Mental Illness <input type="checkbox"/> MR Mild <input type="checkbox"/> MR Moderate <input type="checkbox"/> MR Profound <input type="checkbox"/> MR Severe <input type="checkbox"/> Paraplegia <input type="checkbox"/> Stroke	<input type="checkbox"/> Speech Dysfunction <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Visual Impairment <input type="checkbox"/> None Determinable <input type="checkbox"/> Other Physical Disability <input type="checkbox"/> Other Developmental Disability	<b>Type:</b> <input type="checkbox"/> Nursing Facility <input type="checkbox"/> SSC (DC) <input type="checkbox"/> ICF/DD (Private)		

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<b>Participant Name:</b>		<b>SSN:</b>	
<b>INCIDENT CATEGORIES: <u>Check only those that apply</u></b> <b>Note: All protective services allegations must be verbally reported</b>			
<p><b>Note to Support Coordinator (SC):</b> 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.</p>			
<b>APS Incident Type (Participants 18 years and older)</b> <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation <input type="checkbox"/> Extortion <input type="checkbox"/> Self Neglect			
<input type="checkbox"/> <b>Major Injury</b>		<input type="checkbox"/> <b>Fall</b>	
<input type="checkbox"/> <b>Major Medical Event</b>		<input type="checkbox"/> <b>Death</b>	
<input type="checkbox"/> <b>Major Behavioral Incident:</b>		<input type="checkbox"/> <b>Loss or Destruction of Home</b>	
<ul style="list-style-type: none"> <li>• Attempted Suicide</li> <li>• Suicidal Threats</li> <li>• Self- Endangerment</li> <li>• Elopement/Missing</li> <li>• Self-Injury</li> <li>• Offensive Sexual Behavior</li> <li>• Sexual Aggression</li> <li>• Physical Aggression</li> </ul>		<ul style="list-style-type: none"> <li>• Pharmacy Error</li> <li>• Staff Error</li> <li>• Family Error</li> <li>• Participant Error</li> </ul>	
		<b>Involvement with Law Enforcement:</b> <input type="checkbox"/> Participant arrested <input type="checkbox"/> Participant is a victim of a crime	

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<b>Participant Name:</b>	<b>SSN:</b>
<b>EVENT INFORMATION</b>	
<b>Incident Occurred</b> Date: _____/Time: _____ <input type="checkbox"/> AM or <input type="checkbox"/> PM <b>Incident discovered</b> Date: _____/Time: _____ <input type="checkbox"/> AM or <input type="checkbox"/> PM	<b>Location of incident:</b> <input type="checkbox"/> Home <input type="checkbox"/> Community <input type="checkbox"/> Facility <input type="checkbox"/> Vehicle <input type="checkbox"/> Day Program
<input type="checkbox"/> <b>DSP notified APS</b> Date: _____/Time: _____ <input type="checkbox"/> AM or <input type="checkbox"/> PM <input type="checkbox"/> <b>DSP notified Law Enforcement</b> Date: _____/Time: _____ <input type="checkbox"/> AM or <input type="checkbox"/> PM	
<b>Type of Health Care Admissions and Date of Admissions (check all that apply):</b>	
<input type="checkbox"/> Psychiatric Hospital      Date: _____ <input type="checkbox"/> Acute Care Hospital      Date: _____ <input type="checkbox"/> Rehabilitation Facility      Date: _____ <input type="checkbox"/> Respite Center      Date: _____ <input type="checkbox"/> Emergency Room      Date: _____ <input type="checkbox"/> SS (Developmental Center)      Date: _____ <input type="checkbox"/> Nursing Home      Date: _____ <input type="checkbox"/> Hospice      Date: _____	
<b>Reporter Name:</b>	
<b>Relationship:</b>	
<input type="checkbox"/> APS <input type="checkbox"/> Friend/Neighbor <input type="checkbox"/> OAAS <input type="checkbox"/> Supervisor <input type="checkbox"/> Child <input type="checkbox"/> Guardian <input type="checkbox"/> OBH <input type="checkbox"/> Self <input type="checkbox"/> Child Protection <input type="checkbox"/> Home Health <input type="checkbox"/> OPH <input type="checkbox"/> Sibling <input type="checkbox"/> Curator <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/> Spouse <input type="checkbox"/> Day Program <input type="checkbox"/> HSS <input type="checkbox"/> Parent <input type="checkbox"/> Support Coordinat <input type="checkbox"/> Direct Service Worker <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Physician <input type="checkbox"/> Under Curator <input type="checkbox"/> DSS <input type="checkbox"/> Provider	
<b>Support Coordination Agency:</b>	<b>Agency Telephone #:</b>
<b>Support Coordinator (SC) Name</b>	<b>SC Telephone #:</b>
<b>Direct Service Provider:</b>	<b>DSP Telephone #:</b>

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**HCBS Critical Incident Report Form**

<b>Participant Name:</b>	<b>SSN:</b>		
<b>Critical Incident Description:</b>			
<p>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.)</p>			
<b>Name of Direct Service Provider:</b>	<b>Date reported to SC:</b>	<b>Time:</b>	
<b>Report completed by:</b>	<b>Telephone #:</b>	<b>Date:</b>	<b>Region</b>

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**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

<b>Participant Name:</b>	<b>SSN:</b>		
<b>If participant was released from a facility or outpatient procedure, indicate date and time of release:</b> Date: _____/Time: _____ <input type="checkbox"/> AM or <input type="checkbox"/> PM <b>FOR SC USE ONLY: Meets criteria for Major Medical Event:</b> <input type="checkbox"/> Yes or <input type="checkbox"/> No			
<b>Direct Service Provider Follow-up</b> 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.			
<b>Name of Direct Service Provider:</b>	<b>Date reported to SC:</b>	<b>Time:</b>	
<b>Follow-up completed by:</b>	<b>Telephone #:</b>	<b>Date:</b>	<b>Region</b>