SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name: __________________________ CIN: ____________ RRDS Region: ________

Date alleged incident discovered: __/__/________ Time alleged incident discovered: ______ am / pm

Date alleged incident occurred: __/__/________ Time alleged incident occurred: ________ am / pm

Location and address of alleged incident: ________________________________________________

Did discovering person directly observe the alleged incident? _____ Yes _____ No

Individual(s)/witness(s) present at the time of the alleged incident:

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency/Relationship to Participant</th>
<th>Telephone Number</th>
<th>Waiver Service Provided (If Applicable)</th>
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Classification of the alleged incident: Check all that apply according to the definitions in the Serious Reportable Incident Policy.

a. Allegation of Abuse: (category)
   _____ Physical Abuse     _____ Sexual Abuse     _____ Psychological Abuse
   _____ Neglect            _____ Seclusion       _____ Violation of Civil Rights
   _____ Mistreatment       _____ Exploitation (financial or material)
   _____ Unauthorized or Inappropriate Use of Restraint _____ Use of Aversive Conditioning

b. Other Serious Reportable Incidents:
   _____ Missing Person     _____ Possible Criminal Act    _____ Restraint
   _____ Sensitive Situation _____ Death                   _____ Medication Error/Refusal
   _____ Hospitalization    _____ Medical Treatment Due to Accident/Injury
Participant Name: ____________________________  CIN #: _______________

c. Was the Alleged Incident:  
   ___ Participant only
   ___ Participant to Staff?
   ___ Staff to Participant?
   ___ Participant to Participant?
   ___ Participant to Other?
   ___ Other to Participant?

d. If there was an injury, identify type of injury sustained, and any information regarding the possible cause:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

  e. Describe the alleged incident including anyone who may have been involved, the follow-up steps taken, and person(s) conducting the follow-up?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

f. Include a statement from the participant regarding this alleged incident (use “quotes” when applicable):

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

  g. NOTIFICATIONS:

   □ APS notified  By Whom: _______________
   □ Police notified  By Whom: _______________
   □ Other notified: (specify) _______________________________  By Whom: _______________
   □ Other notified: (specify) _______________________________  By Whom: _______________
SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT (cont)

Participant Name: ________________________________  CIN: ________________

g. NOTIFICATIONS (continued):

Reporter’s Notification to Waiver Entities:

<table>
<thead>
<tr>
<th>Person Notified, Title and Agency</th>
<th>Date Notified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Management Specialist (QMS)</td>
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<tr>
<td>Regional Resource Development Specialist (RRDS)</td>
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<tr>
<td>Service Coordinator/Supervisor</td>
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</tbody>
</table>

Person completing this report/Title ___________________________ Signature ___________________________

Provider Agency ___________________________ Telephone ___________________________ Date ___________________________

Supervisor of person completing this report/Title ___________________________ Signature ___________________________

Provider Agency ___________________________ Telephone ___________________________ Date ___________________________

FOR QMS USE ONLY:

Form Sent to DOH WMS
Date: ___/___/_____

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