SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
POST-INVESTIGATION FOLLOW-UP CONTACT WITH PARTICIPANT

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

Participant Name

Incident Number

Person(s) Contacted:

__ Participant
Date Notified: ________________ Time Notified: ___ am/pm

__ Other Person
Date Notified: ________________ Time Notified: ___ am/pm

Relationship to Participant:

QMS Comments:

Participant/Legal Guardian Comments:

QMS Name
Signature
Date

Copy of this form was sent to: RRDS
Date

Service Coordinator
Date

Investigating Agency
Date

FOR QMS USE ONLY:

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