Print Form

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

SERIOUS REPORTABLE INCIDENT
REGIONAL RESOURCE DEVELOPMENT SPECIALIST (RRDS)
INITIAL RESPONSE

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVERS

☐ Nursing Home Transition and Diversion (NHTD) **NOT YET AVAILABLE**

☐ Traumatic Brain Injury (TBI)

An **allegation** of a Serious Reportable Incident involving

_____
Participant

was reported on _____ by _____
Date Provider Agency

and has been categorized as _____.
Category of Incident

The investigation has been assigned to _____
Provider Agency

located at _____.
Address

The incident number for this Serious Reportable Incident is _____-_____-_____- _____.

This incident number must be used on all subsequent communication regarding this incident.

A Follow-Up Report is due:
within one week of the incident: _____.
Date Due

within thirty calendar days of the incident:_____.
Date Due

Comments:

_____
RRDS Signature Date

Sent to Reporting Provider Agency _____ Sent to Investigating Provider Agency _____
Date Date

Sent to Quality Management Specialist _____
Date