SERIOUS REPORTABLE INCIDENT
PROVIDER FOLLOW-UP REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
TRAUMATIC BRAIN INJURY (TBI)

Participant Name: ____________________________  Incident #_____ - ______ - ______ - ______

Check One:

_____ Seven Day Report  ________________
   Date Completed

_____ Thirty Day Report  ________________
   Date Completed

_____ Additional Follow-Up Report(s)  ________________
   Date Completed

1. What actions (initial or newly conducted) have been taken to investigate this incident (e.g person(s) interviewed, record review, consultations, etc)?
   NOTE: Attach all supporting documentation

2. What have been the results of these actions?

3. What follow-up actions have been taken in response to these results (e.g., changes to the Service Plan, staff changed, police called, etc.)?

4. What has been the results of these follow-up actions (e.g., TBI Waiver participant's behavior has changed, TBI waiver participant is more satisfied with staff, safety of TBI waiver participant has been secured, etc)?
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5. What, if any, long term activities has the provider initiated to decrease, either in frequency or intensity, the possibility of similar incidents occurring in the future?

6. What activities are necessary to complete the investigation?

7. At this time, do you expect that this incident should remain open or closed?
   Why?

Agency Investigator
Signature  Date

Responsible Provider Representative
Signature/Title  Date

Provider Agency  Telephone

For RRDS:
Copy of this report was sent to:
Service Coordinator  Date