

**Department of Health and Hospitals
Office for Citizens with Developmental Disabilities
Home and Community Based Services (HCBS) Critical Incident Report Form**

PARTICIPANT IDENTIFYING INFORMATION:				
Name First:		Name Middle (if known):		Name Last:
Address:		City:	State:	Telephone #:
Region:		DOB:		SSN:
Parish:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Name of Family/Legal Guardian:			Telephone of Family/Guardian:	
Family/Legal Guardian Address				
Service Type:	Marital Status	Race	Living Situation	Legal Status:
<input type="checkbox"/> NOW <input type="checkbox"/> CC <input type="checkbox"/> SW <input type="checkbox"/> ROW <input type="checkbox"/> State Funded	<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 Supports <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
Disability: Person having			Institutional Transition	
<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 <input type="checkbox"/> Other Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No Type: <input type="checkbox"/> Nursing Facility <input type="checkbox"/> SSC (DC) <input type="checkbox"/> ICF/DD (Private)	

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Participant Name:	SSN:

INCIDENT CATEGORIES: Check only those that apply

Note: All protective services allegations must be verbally reported

Child Abuse <input type="checkbox"/> Primary <input type="checkbox"/> Non Primary	Adult <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation <input type="checkbox"/> Extortion <input type="checkbox"/> Self Neglect	Elderly <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation <input type="checkbox"/> Extortion <input type="checkbox"/> Self Neglect		
Child Neglect <input type="checkbox"/> Primary <input type="checkbox"/> Non Primary				
<input type="checkbox"/> Major Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Death	<input type="checkbox"/> Loss or Destruction of Home	
<input type="checkbox"/> Major Illness <i>Check if Sub Category applies:</i> <input type="checkbox"/> Decubitis <input type="checkbox"/> Seizure <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bowel Obstruction	Major Behavioral Incident <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Suicidal threats <input type="checkbox"/> Self Endangerment <input type="checkbox"/> Elopement/missing <input type="checkbox"/> Self injury <input type="checkbox"/> Property destruction <input type="checkbox"/> Offensive Sexual Behavior <input type="checkbox"/> Sexual Aggression <input type="checkbox"/> Physical Aggression	Major Medication Incident <input type="checkbox"/> Pharmacy Error <input type="checkbox"/> Staff Error <input type="checkbox"/> Family Error <input type="checkbox"/> Participant Error <input type="checkbox"/> Non Adherence	Involvement with Law Enforcement <input type="checkbox"/> Participant arrested <input type="checkbox"/> Staff arrested <input type="checkbox"/> Staff issued a Citation for Moving Violation (while participant is in vehicle) <input type="checkbox"/> Participant is a victim of a crime	Restraints Use: BEHAVIORAL <input type="checkbox"/> Personal <input type="checkbox"/> Mechanical <input type="checkbox"/> Chemical MEDICAL <input type="checkbox"/> Personal <input type="checkbox"/> Mechanical <input type="checkbox"/> Chemical

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Participant Name:	SSN:

EVENT INFORMATION

Incident occurred Date: _____ /Time: _____ <input type="checkbox"/> AM or <input type="checkbox"/> PM Incident discovered Date: _____ /Time: _____ <input type="checkbox"/> AM or <input type="checkbox"/> PM	Location of Incident: <input type="checkbox"/> Home <input type="checkbox"/> Vehicle <input type="checkbox"/> Community <input type="checkbox"/> Day Program <input type="checkbox"/> Facility
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DSP notified EPS Date: _____ /Time: _____ AM or PM

DSP notified C.P. Date: _____ /Time: _____ AM or PM

DSP Notified APS Date: _____ /Time: _____ AM or PM

DSP notified Law Enforcement Date: _____ /Time: _____ AM or PM

Type of Health Care Admissions and Date of Admissions (check all that apply):

<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: _____

Reporter Name:

Relationship:

<input type="checkbox"/> APS	<input type="checkbox"/> EPS	<input type="checkbox"/> OAD	<input type="checkbox"/> Supervisor
<input type="checkbox"/> Child	<input type="checkbox"/> Friend/Neighbor	<input type="checkbox"/> OMH	<input type="checkbox"/> Self
<input type="checkbox"/> Child Protection	<input type="checkbox"/> Guardian	<input type="checkbox"/> OPH	<input type="checkbox"/> Sibling
<input type="checkbox"/> Curator	<input type="checkbox"/> Home Health	<input type="checkbox"/> Other	<input type="checkbox"/> Spouse
<input type="checkbox"/> Day Program	<input type="checkbox"/> Hospital	<input type="checkbox"/> Parent	<input type="checkbox"/> Support Coordinator
<input type="checkbox"/> Direct Service Worker	<input type="checkbox"/> HSS	<input type="checkbox"/> Physician	<input type="checkbox"/> Under Curator
<input type="checkbox"/> DSS	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Provider	

Support Coordination Agency:	Agency Telephone #:
Support Coordinator (SC) Name:	SC Telephone
Direct Service Provider:	DSP Telephone #:

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Participant Name:		SSN:	
Critical Incident Description			
<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 individuals 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>			
Name of Direct Service Provider:		Date reported to SC:	Time:
Report completed by:		Telephone #:	Date:

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 Attach **Supplemental Form** to continue
 Critical Incident Report Description as necessary.
 Each additional page **must** be signed and dated.

Participant Name:	SSN:		
<p>Direct Service Provider Follow-up 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.</p>			
Follow-up completed by:	Telephone #:	Date:	Region:

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Continue HCBS Critical Incident Report Form

Note to Support Coordinator (SC) - 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 into the OCDD-approved data system**. This only applies to **APS cases, not EPS or CP**.

Attach **Supplemental Form Appendix C** to continue Critical Incident Report Follow-up.
Each additional page **must** be signed and dated.