Critical incident report form

Please complete and submit this form to UnitedHealthcare Community Plan of Michigan one of the following ways:

- **Email:** critical_incidents@uhc.com
- **Fax:** 855-371-7638

If you need help completing the form, please contact your provider advocate or email us at **critical_incidents@uhc.com**. Thank you.

Member information			
Member's name:	Member's ID number:		
Member's address:	City:	State:	ZIP code:
Member Medicaid ID number:		Member's date of birth:	

Member's gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Cisgender ☐ Transgender ☐ Two spirit ☐ Prefer not to say ☐ Other

Choose the type of incident (choose 1):

☐	Provider no show, particularly when the beneficiary is bed-bound all day or there is a critical need for the service to be provided. Is the member bed-bound? ☐ Yes ☐ No
☐	Exploitation
☐	Illegal activity in the home
☐	Neglect
☐	Physical abuse
☐	Sexual abuse
☐	Suicide attempts
☐	Theft
☐	Verbal abuse
☐	Worker consuming drugs/alcohol on the job
☐	Medication errors
☐	Use of restraints, seclusion or restrictive interventions
☐	Suspicious or unexplained death including suicide. Death should be reported to law enforcement if it is a suspicious death possibly linked to abuse or neglect.

Describe the incident (attach another sheet if necessary) including the who, what, when, where, why and how. Just state the facts. **DO NOT INCLUDE OPINION.**

Describe any actions taken as a result of incident:

Who/what caused the incident (if applicable)?

Name of the person who first became aware of the incident, their relationship to the member and date/time they became aware:

Name: Date: Time:

Where did the incident occur (choose 1)?

Address:

Location type:

- ☐ Family
- ☐ Group home or assisted living facility
- ☐ Medical facility
- ☐ Nursing facility
- ☐ School
- ☐ Place of employment
- ☐ Other (please describe):

Incident date:	Incident time:

Was the incident reported to local emergency authorities, licensing agency, case manager, police/sheriff, parent, other? ☐ No

☐ Yes. Date reported: Type of agency: Name of agency:

Your name:	Your relationship to the member:
Your or your agency's tax ID number:	Your or your agency's email address:

Which best describes you or your agency?

- ☐ Long-term services and supports (LTSS) (please describe below)
- ☐ Primary care provider
- ☐ Specialty provider (please describe below)
- ☐ Other (please describe below)