Critical incident reporting form

This form must be received within **24 hours** of an incident occurring.

Please complete this form and send it to the Quality Management department along with any other supporting documents:
Fax: 855-216-6408 **or email:** nj_c_incidents@uhc.com

Other important numbers:
NJ APS ph: 609-588-6501 | **OOIE** fax: 877-585-6995 | **DCP&P/DC&P** ph: 877-652-2873

Section 1: Member information (complete all sections)		
Subscriber ID number:	**Medicaid ID number:**	
Member name:	**Date of birth:**	**Gender:**
Member address:		
UnitedHealthcare care coordinator (CC) for member:		

Section 2: Critical incident information (complete all sections)	
Date/time incident occurred:	**Date/time provider or UnitedHealthcare rep (CC, etc.) first learned of incident (discovery):**
Date/time reported to UnitedHealthcare clinical quality analyst:	
Who first reported incident to care provider or UnitedHealthcare rep: ☐ Member ☐ Power of attorney ☐ POA/family ☐ Worker ☐ Other:	
Location of incident: ☐ Community/general public ☐ Facility-based setting ☐ Private home ☐ Other:	**Provider type:** ☐ Community living facility care providers (AFC, ALR, CPCH, ALP, CRS) ☐ Day services care providers (SADC, SDP, SDS, MDS – pediatric and adult) ☐ Home care providers (HCBS, HDM, CS, MDD, PERS, IHR) ☐ Home health providers (PDN, PCA) ☐ Individualized service care providers (RM, VM, NMT, C/PT, CTS) ☐ LTC facility care providers (NF, SCNF, CC, RC) ☐ TBI behavioral and cognitive therapy (group and individual) ☐ Therapy care providers (OT, PT, ST, LHT)

Section 2: Critical incident information (complete all sections) (cont.)

Primary medical complexity: (check all that apply)

- ☐ Heart condition (e.g., CVA, hypertension, CHF)
- ☐ Muscular/skeletal (e.g., arthritis, fracture)
- ☐ Neurological (e.g., Alzheimer's, MS, head trauma, quadriplegia, seizure disorder)
- ☐ Psychiatric/mood (e.g., anxiety, depression, behavioral/mental illness, psych diagnosis)
- ☐ Pulmonary (e.g., emphysema, asthma, COPD)
- ☐ Sensory (e.g., vision/hearing impaired)
- ☐ Infections (e.g., pneumonia, TB, UTI)
- ☐ Other diseases (e.g., renal failure, cancer)

Relationship of alleged perpetrator:

- ☐ Authorized representative
- ☐ Brother
- ☐ Daughter
- ☐ Daughter-in-law
- ☐ Father
- ☐ Friend or neighbor (non-caretaker)
- ☐ Granddaughter
- ☐ Grandson
- ☐ Guardian
- ☐ Mother
- ☐ Other relative
- ☐ No relationship/stranger
- ☐ POA
- ☐ Self
- ☐ Self-direction care provider
- ☐ Service care provider
- ☐ Sister
- ☐ Son
- ☐ Son-in-law
- ☐ Spouse/intimate partner

Incident /alleged incident type:

- ☐ Unexpected death of a member
- ☐ Media involvement or the potential for media involvement
- ☐ Physical abuse (including seclusion and restraints both physical and chemical)
- ☐ Psychological/verbal abuse
- ☐ Sexual abuse and/or suspected sexual abuse
- ☐ Fall resulting in the need for medical treatment
- ☐ Medical emergency resulting in need for medical treatment
- ☐ Psychiatric emergency resulting in need for medical treatment
- ☐ Severe injury resulting in the need for medical treatment
- ☐ Suicide attempt resulting in the need for medical attention
- ☐ Neglect/mistreatment, caregiver (paid or unpaid)
- ☐ Neglect/mistreatment, self
- ☐ Neglect/mistreatment, other
- ☐ Exploitation, financial
- ☐ Exploitation, theft
- ☐ Exploitation, destruction of property
- ☐ Exploitation, other

Section 2: Critical incident information (complete all sections) (cont.)

Incident /alleged incident type: (cont.)

- ☐ Theft with law enforcement involvement
- ☐ Failure of member's back-up plan
- ☐ Elopement/wandering from home or facility
- ☐ Inaccessible for initial/on-site meeting
- ☐ Unable to contact
- ☐ Inappropriate or unprofessional conduct by a provider involving member
- ☐ Cancellation of utilities
- ☐ Eviction/loss of home
- ☐ Facility closure, with direct impact to member's health and welfare
- ☐ Natural disaster, with direct impact to member's health and welfare
- ☐ Operational breakdown
- ☐ Other (explain below):

Description of incident (submit additional pages if needed):

Explain the relationship of the critical incident (CI) to the member's present health status:
Is there a risk assessment agreement? Was the backup plan on the member's plan of care? Does the backup plan need to change?

If CI inflicted by another individual, identify alleged offender's name (if possible):

Document relationship of alleged offender and member: ☐ POA ☐ Authorized representative ☐ Guardian ☐ Self-direction care provider

Section 2: Critical incident information (complete all sections) (cont.)

Description of incident (cont.) (submit additional pages if needed):

Actions taken immediately to mitigate risk to member: (What you did to ensure member's safety within 24 hrs. Please list dates and times of attempts to contact these agencies. If faxed, please save confirmation.)

- ☐ **911/EMS** notified
- ☐ **APS** notified if incident involves an adult either suspected or actual physical, mental, sexual abuse or exploitation.
- ☐ **Accrediting agency** notified
- ☐ **DDD** notified
- ☐ **DOH** facility hotline notified
- ☐ **OOIE** notified if incident involves an adult in a nursing home involved either suspected or actual physical, mental, sexual abuse or exploitation
- ☐ **DCP&P/DC&P** notified if incident involves a child either suspected or actual physical, mental, sexual abuse, neglect or financial exploitation
- ☐ Accused worker removed from home and from providing care to UnitedHealthcare member pending investigation
- ☐ New worker assigned to provide services
- ☐ Family member/POA notified
- ☐ Other – Please describe:

Critical incident resolved at the time of the report? ☐ Yes ☐ No

Person submitting this report:

Name:	
Telephone number(s) where you can be reached if more information is needed:	
Title and company name:	
Email address:	Date form submitted to UnitedHealthcare: