

Critical Incident Report Form

Please complete and submit this form to UnitedHealthcare Community Plan:

- When you report abuse, neglect or exploitation of a UnitedHealthcare Community Plan member to the Texas Department of Family and Protective Services (DFPS), or
- When you become aware of a critical incident (including abuse, neglect or exploitation) related to a UnitedHealthcare Community Plan member.

This notification should not take the place of reporting to DFPS (800-252-5400 or TXAbuseHotline.org). For more information, please view our training on **Critical Incident Reporting: Including Abuse, Neglect and Exploitation**.



Submit this form by:

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

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

Member's name:

Member's UnitedHealthcare Community Plan ID number:

Member's address:

Member's date of birth:

Member's UnitedHealthcare Community Plan benefit plan (choose one):

- | | |
|---|--|
| <input type="checkbox"/> Children's Health Insurance Program (CHIP) | <input type="checkbox"/> UnitedHealthcare Connected®
(Medicare-Medicaid Plan) |
| <input type="checkbox"/> STAR | <input type="checkbox"/> UnitedHealthcare Dual Complete®
(Special Needs Plan) |
| <input type="checkbox"/> STAR+PLUS | |
| <input type="checkbox"/> STAR Kids | |
| <input type="checkbox"/> Unknown | |

Is the member on a waiver(choose one)? Yes No Unknown

Service area where the member lives (choose one):

- | | |
|--|--|
| <input type="checkbox"/> Jefferson | <input type="checkbox"/> Medicaid Rural Service Area Northeast |
| <input type="checkbox"/> Harris | <input type="checkbox"/> Nueces |
| <input type="checkbox"/> Hidalgo | <input type="checkbox"/> Travis |
| <input type="checkbox"/> Medicaid Rural Service Area Central | <input type="checkbox"/> Unknown |

Choose the type of incident (choose one):

- | | |
|--|---|
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Criminal victimization |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Death |
| <input type="checkbox"/> Exploitation | <input type="checkbox"/> Other (please describe): |
| <input type="checkbox"/> Unauthorized use of restraint, seclusion, or restrictive interventions | _____ |
| <input type="checkbox"/> Serious injury that resulted in medical intervention or hospitalization | |

Describe the incident (attach another sheet if necessary).

Describe any actions taken as a result of incident.

Who caused the incident (if applicable)?

Name of the person who first became aware of the incident and their relationship to the member:

Where did the incident occur (choose one)?

- | | |
|---|---|
| <input type="checkbox"/> Family home | <input type="checkbox"/> School |
| <input type="checkbox"/> Group home or assisted living facility | <input type="checkbox"/> Place of employment |
| <input type="checkbox"/> Medical facility | <input type="checkbox"/> Other (please describe): |
| <input type="checkbox"/> Nursing facility | |

Incident date:

Incident time:

Was the incident reported to local emergency authorities? Yes. When? _____ No

Was the incident reported to the Texas Department of Family and Protective Services?

(Required for any abuse, neglect, or exploitation incidents)

- Yes. When? _____ DFPS Incident Number: _____
- No

Your name:

Your relationship to the member:

Your or your agency's tax identification number:

Your or your agency's email address:

Which best describes you or your agency?

- Long Term Services and Supports (LTSS) (please describe): _____
- Primary care provider
- Specialty provider (please describe): _____
- Other (please describe): _____

Date you completed this form:



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