DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

Critical Incident Report Form

Member Name ______ Member ID# ______

Address Line 1 ______ City ______

Address Line 2 ______ County ______

Phone ______ Date of Birth ______

Incident Details

Date of Incident ______

Location where incident took place ______

Person reporting incident ______

Address ______

______

Phone ______

Relationship to member: ______

Date and time incident report completed ______

Additional Information:

Type of Incident (Check all that apply.)

- ☐ Suspected physical, mental, sexual abuse and /or neglect/exploitation
- ☐ Inappropriate/unprofessional conduct by a provider involving a member
- ☐ Serious Injury sustained by a member
- ☐ Suicide attempt
- ☐ Unexpected Death of a member
- ☐ Medical Emergency
- ☐ Restraints/Seclusion/Isolation
- ☐ Medication Error
- ☐ Suspected theft or financial exploitation of a member
- ☐ Other ___________________________

If Hospitalized, Date of Admission ________ Date of Discharge ________

Description of Event:

If the event involved the use of restraint/seclusion/isolation, provide the following details:

Type ________

Date ________

Time ________

Length ________

Name(s) and role(s) of all involved in this incident:

Names of those who witnessed this incident:

Person filing and reporting this incident:

Name: ________

Agency: ________

Phone Number: ________

Email Address: ________

Describe any medical treatment provided to member:

Medical treatment provided by:

Name: N/A

Address:

Phone:

Contacts made on behalf of member: (Ombudsman, Protection & Advocacy, Law Enforcement, Child Protective Services, Adult Protective Services, etc.)

Names and relationships of those contacted on behalf of the person involved in the Incident (legal representative, relatives, friends, or other informal supports):

Action taken to resolve concerns by Case Manager or Transition Coordinator:

Health Options Medical Director follow up actions:

Click here to enter text.

Follow: Case Management Quality Monitoring and Oversight

Date Report Received:

Concerns identified by CM Quality Monitoring and Oversight :

Incident closed?: Yes ☐ No ☐

Action Taken by DMMA/Resolution/Concerns:

Date Action Taken:

Follow-Up Planned:

Signature Date

Chief of MMDS or Designee