

- MDCSW - Send to DHMH LAH - Send to DHMH Older Adults - Send to MDoA
- RTC - Send to DHMH Autism - Send to MSDE Model - Send to DHMH

REPORTING INFORMATION (Check/enter all that apply)	EVENT INFORMATION (Check/enter all that apply)
<p><u>Initial Telephone Report:</u> <input type="checkbox"/> CM <input type="checkbox"/> OSA <input type="checkbox"/> OHS <input type="checkbox"/> PROVIDER</p> <p><u>Date/Time of Telephone Report:</u> /</p> <p><u>Name of Reporter:</u></p> <p><u>Title/Agency (if applicable):</u></p> <p><u>Relationship to Participant/Applicant:</u></p> <p><u>Phone:</u> ext.</p> <p><u>Email Address:</u></p> <p><u>Person Completing the Form:</u></p> <p><u>Date Form Completed and sent to CM:</u></p> <p><u>Name (If different from reporter):</u></p> <p><u>Title/Agency (if applicable):</u></p> <p><u>Relationship to Participant/Applicant:</u></p> <p><u>Phone:</u> ext.</p> <p><u>Email Address:</u></p>	<p><u>Event Date/Time:</u> /</p> <p><u>Event Type:</u> <input type="checkbox"/> Incident <input type="checkbox"/> Complaint <input type="checkbox"/> Both</p> <p><u>Participant/Applicant Name:</u></p> <p><u>Address:</u></p> <p><u>City/State/Zip:</u></p> <p><u>Enter MA#:</u></p> <p><u>DOB:</u> Gender: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p><u>CM Name:</u></p> <p><u>Provider Information (If involved or present):</u></p> <p><u>Provider#:</u> <u>Provider Type:</u></p> <p><u>Agency/ALF Name (if applicable):</u></p> <p><u>Contact Person:</u></p> <p><u>Phone:</u> ext.</p> <p><u>Date of Service Interruption (if applicable):</u> Start: End:</p>
ALLEGED INCIDENT(S) (Check/enter all that apply)	
<p><u>Abuse:</u> <input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Verbal <input type="checkbox"/> Emotional Neglect: <input type="checkbox"/> Nutrition <input type="checkbox"/> Medical <input type="checkbox"/> Self <input type="checkbox"/> Environment</p> <p><u>Accident/Injury (Requiring Treatment beyond First Aid):</u> <input type="checkbox"/> Fall <input type="checkbox"/> Fracture <input type="checkbox"/> Burn <input type="checkbox"/> Laceration/Wound <input type="checkbox"/> Other</p> <p><u>Emergency Room Visit:</u> <input type="checkbox"/> Hospitalization: <input type="checkbox"/> In-Patient Psychiatric Hospitalization: <input type="checkbox"/> Death: <input type="checkbox"/> Suicide: <input type="checkbox"/> Suicide Attempt: <input type="checkbox"/></p> <p><u>Abandonment:</u> <input type="checkbox"/> Elopement/Missing Person: <input type="checkbox"/> Exploitation: <input type="checkbox"/> Financial / Theft Rights Violation: <input type="checkbox"/></p> <p><u>Seclusion/Restraint:</u> <input type="checkbox"/> Physical <input type="checkbox"/> Chemical <input type="checkbox"/> Involuntary Seclusion</p> <p><u>Treatment Error:</u> <input type="checkbox"/> Medication <input type="checkbox"/> Other Treatment Error: Other Incident Type: <input type="checkbox"/></p>	
COMPLAINT (Check/enter all that apply)	
<p><u>Quality of Care/Service Issue:</u> <input type="checkbox"/> Other: <input type="checkbox"/></p> <p><u>Name of Complainant:</u> Address: Phone: ext. Email Address: City/State/Zip:</p>	
<i>Explain dissatisfaction with any aspect of the program's operations, activities, or administration under the Description of Event section on pg. 2.</i>	

Appendix C

Medicaid Home and Community-Based Services
Reportable Event (RE) Form

Participant/Applicant Name:
Event Date:

DESCRIPTION OF EVENT AND RESPONSE
This section must be completed by the Provider/Participant/Family/Other and should include a description of the incident and/or complaint (event) and what actions were taken to appropriately respond to the event. If applicable, complete Contact Information page

SUBMIT WRITTEN RE FORM TO THE CM WITHIN REQUIRED TIMEFRAMES: 7 DAYS OF THE EVENT DATE.

THE DESCRIPTION SHOULD INCLUDE THE FOLLOWING INFORMATION:
Immediate actions taken to safeguard the participant;
Names and title(s) of individual(s) present at time of event;
Diagnosis: (For ER visits or hospitalizations);
Current status of the participant prior to submission of this report to the CM;
Any other important information that fully describes the event

Is other documentation attached? (e.g. discharge summary, ALF incident report, additional handwritten pages): Yes No

DESCRIPTION OF EVENT (Handwritten entries must be printed and legible):

Appendix C

Medicaid Home and Community-Based Services
Reportable Event (RE) Form

Participant/Applicant Name:
Event Date:

Case Manager/Service Coordinator:

CONTACT INFORMATION					
This section must be completed. All applicable agencies or individuals should be contacted.					
Select all agencies/individuals contacted	Contact Name	Date	Telephone #	Email	Address
<input type="checkbox"/> Case Manager					
<input type="checkbox"/> OSA					
<input type="checkbox"/> Law Enforcement Agency					
<input type="checkbox"/> Adult (APS) or Child Protective Services (CPS) * (APS or CPS MUST be contacted for all alleged abuse, neglect or exploitation events.)					
<input type="checkbox"/> Office of Health Care Quality					
<input type="checkbox"/> Authorized Guardian/Representative/Family *Participant Authorized Release <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Release:					
<input type="checkbox"/> Ombudsman Program					
<input type="checkbox"/> Local School System					
<input type="checkbox"/> Other:					

Comments:

Medicaid Home and Community-Based Services
Reportable Event (RE) Form

Participant/Applicant Name:
Event Date:

CM/OSA INTERVENTION AND ACTION PLAN(S)

This section must be completed by the CM/OSA. A copy of the RE form must be maintained in the participant/applicant file and a copy must be sent to the OSA, if applicable.

SUBMIT COMPLETED RE FORM TO THE OSA WITHIN REQUIRED TIMEFRAMES: 7 DAYS FROM THE EVENT DATE.

RESPOND TO ALL APPLICABLE QUESTIONS:

The provider/participant/family/other responded to the event appropriately? Yes No N/A

The provider/participant/family/other contacted APS/CPS if the event was abuse, neglect, or exploitation? Yes No N/A

The provider contacted the guardian/representative? Yes No N/A

The participant was provided with their right to appeal for an adverse action (e.g. denial or reduction of services)? Yes No N/A

Describe Findings, Interventions, Follow-up, and Corrective Action Plan(s):

To be completed by OSA only

Date Report received:

OSA Review Needed: Yes No OSA Staff Assigned:

Assignment Date: Review Due Date: Case Closure date: Status Letter Date (if applicable):