**Critical Incident Investigation**

**Aging Waiver & New Choices Waiver**

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| **Participant’s name:**      | **Waiver program:** New Choices Waiver |
| **DOB:**       | **Date of incident:**       |
|  **Participant’s Mailing Address:**       | **Location of incident:**   |
| **Does the participant have a legal guardian?** [ ] Yes [ ] No **Name, Relation & Mailing Address:**       | **Is there another involved representative?** [ ] Yes [ ] No**Name & relation:**       |
| **Participant’s Case Manager****Name:**       **AAA** (if applicable):   **Phone #:**       **Email:**       |
| **Please respond to the following questions, providing as much detail as possible.** (Please disregard questions (or parts of questions) that do not relate to this incident)**:** |
| 1. **Summary of Incident/Event**

**Please provide a detailed summary of the incident.**(For a **missing person**, section 3 is also required.)   |
| 1. **Precipitating Events/Patterns of Behavior**
* **Do the monthly summaries and/or activity logs reflect any precipitating events or patterns of behavior leading up to this incident?** [ ] Yes [ ] No
* **If yes, please describe.**
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| 1. **Missing Person Timeline**
* **This is a missing person incident:** [ ] Yes [ ] No
* **If yes, please provide a timeline that describes the course of known events from when the participant was last seen to when found or to the present if not yet found. Please include when the case manager, Operating Agency leadership, law enforcement, emergency responders, providers, family/guardian, or others etc. were notified**

     * **Was an Endangered Person Advisory Alert Issued?**

[ ] Yes Date and time issued:       Name of agency that issued the Advisory:       [ ] No Describe why not:      |
| 1. **Participant’s Health/Medical Issues**
* **Participant’s diagnoses and any other health/medical issues:**
* **Participant’s medications and dosages:**
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| 1. **Post Incident Medical Assessment**
* **The incident report provides a detailed description of the Post Incident Medical Assessment:** [ ] Yes (if yes, not necessary to complete this section.) [ ] No (if no, please provide additional details below).

      * **After the incident, the participant was evaluated by a nurse or a physician to determine the need for medical attention?** [ ] Yes [ ] No
* **If no, please explain why not.**
* **If yes, please describe when and the medical intervention that occurred.**
* **If yes, please describe the findings and recommendations for any additional medical follow up.**

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| 1. **Referral to APS/Law Enforcement**
* **Is this a case of suspected abuse, neglect or exploitation?** [ ] Yes [ ] No
* **If yes, was this incident referred to** (check all that apply):
	+ APS [ ]  Date submitted: Referral number:
		- Who made the referral?
	+ Medicaid Fraud [ ]  Date:
	+ Law Enforcement [ ]  Date:       Name of Law Enforcement Agency:
 |
| 1. **Services at the Time of the Incident**
* **What service(s) was the participant scheduled to receive at the time of the incident?**
	+ **Were these services delivered as authorized on the care plan?** [ ] Yes [ ] No, if no, please describe why not)
* [ ] NA (No services were scheduled to be provided at the time of the incident)
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| 1. **Additional Reviews or Investigations**
* **Did the incident trigger a provider review conducted by the Office of Licensing (DHS), Bureau of Licensing (DOH), the Bureau of Internal Review and Audit (DHS), the LTC Ombudsman, or other agency?** [ ] Yes Date:       [ ] No [ ] NA
	+ **Who made the referral?**
* **If yes, please provide a summary of the review findings, including any corrective actions that were issued.** (Please feel free to attach the formal review findings.)

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| 1. **Changes to the Care Plan**
* **Will changes be made to the care plan?** [ ] Yes [ ] No
	+ **If yes, please describe:**
	+ **If no, will any new interventions be implemented?** [ ] Yes [ ] No
		- **If yes, please describe:**
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| 1. **Process Improvements**
* **Required is a description of improvement processes/safeguards put into place as a result of the analysis of this incident/event. For example, medical/environmental interventions, training opportunities, policy changes, etc. If process improvements/safeguards are not applicable please mark as N/A and describe why.**

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| **Investigation completed by** (names and titles)**:**       **Date:**        |
| **Section to be Completed by OA/SMA** |
| **Incident Summary (if not completed in #1):**      **Follow Up Questions:**      **Comments/Resolution & Recommendations:**       |
| **Notification Within Protocol Time Frame:** [ ] **Yes** [ ] **No**If no, describe reason for delay:       |
| **Incident Type:**       | **Investigation Closure Date:**       |