New York State Department of Health
Division of Home and Community Based Services

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name:_____ CIN: _____ RRDS Region: _____

Date alleged incident discovered: __/__/__ Time alleged incident discovered: _____ am / pm

Date alleged incident occurred: __/__/__ Time alleged incident occurred: _____ am / pm

Location and address of alleged incident: _____

_____

Did discovering person directly observe the alleged incident? _____ Yes _____ No

Individual(s)/witness(s) present at the time of the alleged incident:

Name	Agency/Relationship to Participant	Telephone Number	Waiver Service Provided (If Applicable)

Classification of the alleged incident: Check all that apply according to the definitions in the Serious Reportable Incident Policy.

a. Allegation of Abuse: (category)

____ Physical Abuse ____ Sexual Abuse ____ Psychological Abuse
____ Neglect ____ Seclusion ____ Violation of Civil Rights
____ Mistreatment ____ Exploitation (financial or material)
____ Unauthorized or Inappropriate Use of Restraint ____ Use of Aversive Conditioning

b. Other Serious Reportable Incidents:

_____Missing Person _____Possible Criminal Act _____Restraint
_____Sensitive Situation _____Death _____Medication Error/Refusal
_____Hospitalization _____Medical Treatment Due to Accident/Injury

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT (cont.)

Participant Name:_____ CIN #: _____

c. Was the Alleged Incident:

___ Participant only
___ Participant to Staff?
___ Staff to Participant?
___ Participant to Participant?
___ Participant to Other?
___ Other to Participant?

d. If there was an injury, identify type of injury sustained, and any information regarding the possible cause:

_____
_____
_____
_____
_____

e. Describe the alleged incident including anyone who may have been involved, the follow-up steps taken, and person(s) conducting the follow-up?

f. Include a statement from the participant regarding this alleged incident (use “quotes” when applicable):

g. NOTIFICATIONS:

☐ APS notified By Whom: _____
☐ Police notified By Whom: _____
☐ Other notified: (specify) _____ By Whom: _____
☐ Other notified: (specify) _____ By Whom: _____

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT (cont)

Participant Name:_____ CIN: _____

g. NOTIFICATIONS (continued):

Reporter's Notification to Waiver Entities:

	Person Notified, Title and Agency	Date Notified
Quality Management Specialist (QMS)		
Regional Resource Development Specialist (RRDS)		
Service Coordinator/ Supervisor		

_____
Person completing this report/Title Signature

_____
Provider Agency Telephone Date

_____
Supervisor of person completing this report/Title Signature

_____
Provider Agency Telephone Date

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____