SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
POST-INVESTIGATION FOLLOW-UP CONTACT WITH PARTICIPANT

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

Participant Name _____ Incident Number _____

Person(s) Contacted:

___ Participant Date Notified: _____ Time Notified: ____ am/pm

___ Other Person _____ Relationship to Participant: _____
Date Notified: _____ Time Notified: ____ am/pm

___ Other Person _____ Relationship to Participant: _____
Date Notified: _____ Time Notified: ____ am/pm

Participant/Legal Guardian Comments: _____

QMS Comments: _____

QMS Name Signature Date

Copy of this form was sent to: RRDS _____ Date

Service Coordinator _____ Date

Investigating Agency _____ Date

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