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 _____ ☐ Check if date of incident is approximate

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 of a member

☐ Suspected theft or financial exploitation of a member

☐ Inappropriate/unprofessional conduct by a provider involving a member

☐ Other _____

☐ Serious Injury sustained by a member

☐ Unexpected death of a member

If Hospitalized, Date of Admission _____ Date of Discharge _____

Description of Event:

If the event involved physical, mental, sexual abuse and/or neglect/exploitation, 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 Incident

Name _____

Agency _____

Phone Number _____

Email Address: _____

Medical Treatment Provided

Describe any medical treatment provided to member:

Medical treatment provided by:

Name

Address

Phone

Contacts made on behalf of member: (examples: 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 Care Coordinator:

Medical Director follow up actions:

Follow Up: Care Coordinator/Quality Monitoring and Oversight (DMMA)

Date Report Received

Concerns identified by Care Coordinator/Quality Monitoring and Oversight (DMMA):

Incident closed?: Yes ☐ No ☐

Action Taken by DMMA/Resolution/Concerns:

Date Action Taken

Follow-Up Planned:

Signature Date

Chief of Managed Care Operations or Designee