Provider Incident Report Form

(Use of this form is optional, reporting incidents is required)

Date MCO Informed of the Incident (must be within 24 hours of incident):	
Date Guardian or POAHC was informed of the incident (if applicable)	**Date:** ☐ **NA**

Member Name:		**Date of Incident:**	
Community Resource Coordinator:		**Time of Incident:**	☐ A.M. ☐ P.M.
Health and Wellness Coordinator:			
Provider Name:			
Person Completing Form & Title:		**Date:**	
Other Entity(s) Notified: e.g. APS, DQA, or OCQ		**Date:**	

Type and extent of harm/injury experienced by the member as a result of the incident (to include property damage):	
Type and extent of harm/injury experienced by Others as a result of the incident (to include property damage):	
Did the member or others require medical attention?	**Yes** ☐ **No** ☐ **If yes, please explain:**
Describe where the incident took place:	
Describe what was occurring prior to the incident: (include what you/staff and the member were doing)	
Incident Summary (what happened/facts of the event, be sure to include titles following names)**:**	

Immediate actions taken (by you or others upon discovery of the incident):	
Root Cause* of the Incident (casual factors): **The fundamental breakdown or failure of a process, which when resolved, prevents a recurrence of the problem.*	
Describe how the incident could have been prevented:	
Describe what is being done to prevent a similar incident (practices and/or actions that have been or will be taken)**:**	

Signature of Person Completing Report *Title* *Date*