APPENDIX A – Centennial Care Behavioral Health Critical Incident Report Form - July 1, 2017

Centennial Care Behavioral Health Critical Incident Report Form

<u>You must report an incident within 24 hours of becoming aware of it.</u>
In the event that an incident occurs on a weekend or holiday, report the incident next business day.

In addition to notifying the MCO, providers must report Abuse, Neglect and Exploitation to:
Adult Protective Service (APS): Telephone: **(866) 654-3219 Fax: (505) 476-4913**
Child Protective Service (CPS): Telephone: (855) 333-7233 or Fax: (505) 841-6691
BHSD Fax: 505-476-9272

Member Centennial Care Category of Eligibility #: _____
The HSD web portal accepts COEs 001, 003, 004, 081, 083, 084, 090, 091, 092, 093, 094, 100w/NFLOC 200w/NFLOC. 095* Starting 01/01/2016

Be sure that clinical notes are clear and adequate, do not use acronyms if at all avoidable, and diagnoses should contain a valid code and definition from the current DSM as relevant.

Consumer Demographic Information			
First Name	Last Name	Middle Initial	DOB
SSN#	Telephone	Cellular	Gender ☐ Male ☐ Female
Address	City	State	Zip

Clinical Information/Diagnosis:

BH Treatment Setting/ LOC and as identified in 8.321.2 NMAC SPECIALIZED BEHAVIORAL HEALTH SERVICES. Check all that are applicable,

___ ARTC ___ RTC ___ Group Home ___ TLS ___ Methadone ___ Day Treatment	___ TFCI ___ TFCII ___ CMHC ___ CSA ___ BHA	___ MST ___ ACT ___ IOP ___ BMS ___ CCSS	___ Rural Health Centers ___ Indian HS ___ Other(specify) _____	___ Outpatient (specify) _____ ___ Acute Inpatient Hospitalization _____

Incident Information

Date of Incident:	Time of Incident: AM/PM	Incident Location: ☐ Home ☐ Facility ☐ Other (specify):
Transportation required: ☐ Yes ☐ No		Provided By: ☐ Provider /staff member ☐ Emergency service ☐ Self ☐ Other (specify):
Date provider first aware of incident:	Date reported to APS :	Date reported to CPS:

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Type of Incident

_ **Abuse**
- _ **Towards consumer by staff person**
- _ **Towards consumer by Other**
- _ **Consumer towards other, not involving law enforcement**

_ **Neglect**
- _ **Towards consumer by staff person**
- _ **Towards consumer by Other**
- _ **Self-neglect**

_ **Exploitation**
- _ **Towards consumer by staff person**
- _ **Towards consumer by Other**

_ **Elopement and Missing recipients (for a period longer than 24 hours)**
- _ **Home**
- _ **Facility**

_ **Self-injurious behaviors**
- _ **Consumer's behavior that results Emergency Room (ER) visits**
- _ **Consumer's behavior that results law enforcement intervention**
- _ **Attempted suicide – not requiring emergency services**

_ **Death**
- _ **Unknown- requiring follow up with Office of Medical Examiner**
- _ **Suicide**
- _ **Medication/treatment error**
- _ **Natural causes**
- _ **Accident**
- _ **Secondary to use of restraints**
- _ **Member Death by Homicide**

_ **Emergency Services/Crisis Intervention**
- _ **Attempted suicide**
- _ **Attempted homicide**
- _ **Law Enforcement**
- _ **Protective Custody**
- _ **Medication / Treatment Errors**
- _ **Member committed Homicide**

_ **Sexual Behaviors**
- _ **Member to member sexual contact while in treatment setting**
- _ **Any non-consensual sexual contact**
- _ **Sexual assault/ abuse/ rape**
- _ **Indecent exposure**

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_ **Environmental Hazard**

Incident Description:
Follow up and Disposition of the Incident:
Future Actions:
Funding Source: ☐Medicaid ☐FFS ☐CYFD ☐BHSD

Reporting Agency Name:	Address/City State/ Zip Code:	Telephone:
Reporting individual name and title:		Date submitted:

Please fax this form to: _____ Insert fax number you have sent form to.