***Please complete and submit this form within 24 hours of learning of a Reportable Incident to*** ***Lauren.Cramer@sphp.com***

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| **Care Management Agency Information** |
| **Care Management Agency:** |  |
| **Person Completing Form:** |  |
| **Phone:** |  | **Email:** |  |
| **Date Incident Discovered:** |  | **How was Incident Discovered?** | Choose an item |

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| **Communication with Member** |
| **Date of Last Contact:** |  | **Date of Last Face-to-face Contact:** |  |
| **Last contact Type:** | Choose an item |
| **Complainant:***Person who reported the incident* | Category:Choose an item. | First Name: | Last Name: |

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| **Member Information** |
| **Member Name:** |  | **Member CIN:** |  |
| **Member's Location at time of this report:** | Select Location | **Member DOB:** |  |
| **Date of HH Enrollment:** |  | **Current MCO:** | Select MCO |

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| **Incident Information** |
| **Incident Type:** | Select Incident Type |
| **Date Incident Occurred:** |  |
| **Incident Description:** |  |
| **Summary of Actions Taken to Date:** |  |
| **Date of first Action Taken:** |  |
| **Categories of Action Taken:***(select all that apply)* |  [ ]  Documentation of Incident / Complaint |  [ ]  Follow-up with Authorities / Obtain Outcome |  [ ]  Follow-up with Providers / Collaterals |  [ ]  Mandated Reported Compliance |
|  [ ]  Network / Organization Training |  [ ]  New Policy / Procedure Needed |  [ ]  Other – See Action Summary |  [ ]  Care Coordinator Training |
|  [ ]  Record Review / Audit |  [ ]  Referral to Another Service |  [ ]  Report to Authorities Concern |  [ ]  Review and Update Plan of Care |
|  [ ]  Safety of Member Follow-up |  [ ]  Timely Notification Issue |  [ ]  Update Services Already in Place |  [ ]  Updated Policy / Procedure |
| **Negative Impact to Member:** |  |
| **Media Coverage:***If coverage, please provide links if possible* |  |