Critical Incident Report Form

UnitedHealthcare Community Plan

Please complete and submit this form to UnitedHealthcare Community Plan of Michigan:

Submit this form by:

- Email — **critical_incidents@uhc.com**
- Fax — **855-371-7638**

If you need assistance completing the form, please contact your provider advocate or email us at critical_incidents@uhc.com. Thank you.

Member's name:

Member's UnitedHealthcare Community Plan ID number:

Member's address:

Member Medicaid ID Number:

Member's date of birth:

Choose the type of incident (choose one):

- ☐ Provider No Show, particularly when the beneficiary is bed-bound all day or there is a critical need for the service to be provided
- ☐ Exploitation
- ☐ Illegal activity in the home with potential to cause a serious or major negative event
- ☐ Neglect
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Suicide Attempts
- ☐ Theft – of anything
- ☐ Verbal Abuse
- ☐ Worker consuming drugs/alcohol on the job
- ☐ Medication errors resulting in emergency medical treatment or hospitalization (If the medication error does not result in death or loss of a limb or function or risk thereof then it does not need to be reported in the critical incident reporting system.)

☐ Injuries requiring medical treatment

☐ Hospitalization or emergency department visits within 30 days of previous hospitalization due to neglect or abuse

☐ Other – other event that creates a significant or potential risk of substantial or serious harm to the physical or mental health, safety or well-being of a wavier participant already listed (fire, drive by shooting, car accident, etc.)

☐ Restraints, seclusion or restrictive interventions

☐ Suspicious or unexplained death that the waiver agency, or other entity, reports to law enforcement and that is related to provided services, supports, or care. Please choose any of the following related to the suspicious or unexplained death:
- ☐ Medical Examiner or Coroner's Report obtained
- ☐ Police Report Obtained
- ☐ Death Certificate Obtained

Describe the incident (attach another sheet if necessary) including the Who, What, When, Where, Why and How. Just state the facts. DO NOT INCLUDE OPINION.

Describe any actions taken as a result of incident:

Who/What caused the incident (if applicable)?

Name of the person who first became aware of the incident, their relationship to the member and date/time they became aware:

Name: Date: Time:

Where did the incident occur (choose one)?

Adress: _____

Location Type:

☐Family
☐Group home or assisted living facility
☐Medical facility
☐Nursing facility
☐School
☐Place of employment
☐Other (please describe):

Incident date:	**Incident time:**

Was the incident reported to local emergency authorities, licensing agency, Case Manager, Police/Sheriff, Parent, Other? ☐No

☐Yes. Date Reported: Type of Agency: Name of Agency:

Your name:

Your relationship to the member:

Your or your agency's tax identification number:

Your or your agency's email address:

Which best describes you or your agency?

☐Long Term Services and Support (LTSS) (please describe below)

☐Primary care provider

☐Specialty provider (please describe below)

☐Other (please describe below)