MOLINA HEALTHCARE

# Molina Healthcare of Washington, Inc. Critical Incident Form

Email Completed Form To:
MHW.Critical_Incidents@molinahealthcare.com

| Patient/Client Information | | | |
|---|---|---|---|
| **Provider One #** | | **Date of Birth** | |
| **Last Name** | | **First Name** | |
| **Gender** | ☐ Male ☐ Female<br>☐ Other ☐ Not Specified | **Race** | |
| **County of Residence** | | **Date of Report** | |
| **County of Incident** | | **Other Information** | |
| **Date of Last Visit** | | **Date of Last Med Mgmt** | |

| Incident Information | | | |
|---|---|---|---|
| **Date of Incident** | | **Time of Incident (if known)** | |
| **Facility** | | **Facility Contact Info** | |
| **Level of Care** | ☐ Inpatient ☐ Residential Tx ☐ Crisis Stabilization ☐ IOP<br>☐ Outpatient ☐ FQHC ☐ Independent Provider<br>☐ Other (please specify) _____ | | |
| **Location of Incident (if known)** | | | |
| **Type of Incident (Required by ASO/MCOs)** | Incidents that occurred to a member/client while they were within a contracted behavioral health facility, FQHC or by an independent provider | | |
| | ☐ | Abuse, Neglect or Sexual/Financial Exploitation Perpetrated by Staff | ☐ Death |

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| | | | | |
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| **Type of Incident (Required by ASO/MCOs)** | ☐ | Severely adverse medical outcome or death occurring within 72 hours of transfer from a contracted behavioral facility to a medical treatment facility (new requirement for January 2021) **(Required by MCO ONLY)** | ☐ | Physical or Sexual Assault Perpetrated by Another Individual |
| | Incidents that occurred **by** a member/client (allegedly committed the following) – member must have a current behavioral health diagnosis or history of behavioral health treatment in the previous 365 days | | | |
| | ☐ | Homicide or Attempted Homicide | ☐ | Arson |
| | ☐ | Assault or action resulting in serious bodily harm which has the potential to cause disability or death | ☐ | Kidnapping |
| | ☐ | Sexual Assault | | |
| | Other Incidents | | | |
| | ☐ | Unauthorized leave from a behavioral health facility during an involuntary detention | ☐ | Any event that has or will attract media attention – include link to media source in description |
| | ☐ | Incident posing a credible threat to the member's safety | ☐ | Suicide Attempt/Completed |
| | ☐ | Poisoning/Overdose – unintentional or intention unknown | ☐ | Poisoning/Overdose Substance, if known |

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| | | | |
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| **Other Incidents (Required by ASO or another Entity/ Provider)** | ☐ Elopement (resulting in patient death or serious injury) | ☐ Bomb threat | ☐ Sexual behavior, abuse, or assault on a member or staff within or on the grounds of a healthcare setting |
| | ☐ Fall (resulting in death or serious injury while on the grounds of a healthcare setting) | ☐ Any serious injury in a treatment setting resulting in urgent/ emergent interventions | ☐ Self-inflicted harm (resulting in death or serious injury while in treatment) |
| | ☐ Accident (resulting in death or serious injury within a healthcare setting) | ☐ Medications/ Treatment error (resulting in death or serious injury) | ☐ Unscheduled event that results in the evacuation of a program/facility |
| | ☐ Unplanned transfers to a medical unit | ☐ Other occurrences, not listed, representing actual serious harm to a member (provide explanation) Click here to enter text. | |
| | ☐ Death or serious injury of a staff or public citizen(s) at a licensed site | ☐ Credible threat to a staff member that occurs at a licensed facility resulting in a report to LE, a restraining/protection order, or a workplace safety plan | |
| | ☐ Alleged abuse or neglect of a client of a serious or emergency nature, by a workforce member or another individual in services | ☐ Theft or loss of client data in any form | ☐ Any incident reported to the Medicaid fraud unit |
| | ☐ A natural disaster or outbreak of a communicable disease that presents a substantial threat to licensed facility operation or client safety | ☐ Breach or loss of client data considered reportable under HITECH that would allow for unauthorized use of client PHI | ☐ A life event that requires an evacuation or that is a substantial disruption to the facility |
| **Description of Incident** | | | |

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| Other Individuals Involved - complete this section if you know of other individuals involved in this incident | | | |
|---|---|---|---|
| Last Name | | First Name | |
| Relationship | | How were other individuals involved? | |

| Other Agency/Facilities Notified – complete this section if you know of any agencies/facilities notified (i.e. APS/CPS/local police) | | | |
|---|---|---|---|
| Date | | Type of Agency or Facility Notified | |

| Reporting Information | | | |
|---|---|---|---|
| Name/Role of person reporting incident | | Provider Group/CCO/ ASO/Other | |
| Date Submitted | | Phone number of person reporting | |
| Email address of person reporting | | | |
| Other comments or information regarding incident | | | |
| Steps taken to ensure safety of member/client; current disposition of member/ client: (outreach attempts, safety plans, wellness check, hospitalization, appointments, referrals) | | | |
| Steps taken to ensure safety of facility, employees, records, etc. and business continuity | | | |