CRITICAL INCIDENT REFERRAL TEMPLATE (Medicaid Members Only)

Please securely submit completed template to MedicaidCriticalIncident@MolinaHealthcare.com.

* Denotes when a response is required

*Template Completed by: _____   *Provider: _____

*Provider Contact Information: _____

Individual Information: IMS Incident ID (This item for Molina use only):

*Medicaid ID: _____   *First Name: _____   *Last Name: _____

*Date of Birth: _____   Email address: _____

*Phone Number: _____   Alternate phone number: _____

*Street address: _____

*City: _____   *State: _____   *Zip Code: _____

Alternate Address: _____

Resident address same as mailing address?   YES ☐   NO ☐

Mailing street address: _____

Authorized Representative/Guardian/POA Information (If applicable): _____

*Does the member have an authorized representative, guardian or POA?   YES ☐   NO ☐

Reminder to staff: must complete if yes

Name: _____   Phone number: _____

Address: _____

Relationship (family, friend, etc.): _____

Please check appropriate box: *Answer option – single selection*

Guardian ☐   Authorized Representative ☐   POA ☐

Event Information:

*Location of the event: _____

*Was this reported in the media?   YES ☐   NO ☐

TV ☐   Newspaper ☐   Radio ☐   Other ☐ _____

*Date and time of occurrence (when did this happen?): Click or tap to enter a date. _____

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*Date and time of discovery (when did you find out?): Click or tap to enter a date. _____

Reporter Information:

*First name: _____   *Last Name: _____   *Phone number: _____

*Address: _____

*Reporter's relationship to the member: _____   Email: _____

*Reporter Date of discovery (if different than the date/time of identification): Click or tap to enter a date. ____

Alleged Violator Information (If applicable):

*Is there an alleged violator?   YES ☐   NO ☐

Reminder to staff: must complete if yes

Alleged Violator: _____   Alleged Violator Phone: _____

Alleged Violator Address: _____

Alleged Violator Relationship to Member: _____

Do you want to add additional violator information?   YES ☐   NO ☐

Reminder to staff: must complete if yes

Up to 5 violators

Provider/Agency Information (If applicable):

*Is there provider/agency?   YES ☐   NO ☐

Reminder to staff: must complete if yes

Provider/Agency Name: _____

Provider/Agency Type: _____   Provider/Agency Phone: _____

Provider/Agency Address: _____

Do you want to add additional provider/agency information?   YES ☐   NO ☐

Reminder to staff: must complete if yes

Up to 3 provider/agencies

*Notification of agencies: (Please check appropriate boxes as applicable.) *Answer option – multiselect*

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☐Ohio Board of Nursing   ☐Ohio Department of Health

☐Local Law Enforcement   ☐Coroner's Office

☐Local County Board of Developmentally Disabled   ☐Local Public Adult Protective Service Agency

☐Ohio Long Term Care Ombudsman   ☐Alcohol, Drug Addiction Mental Health Services

☐Ohio Attorney General   ☐Local Probate Court

☐Primary Care Provider   ☐Ohio Department of Transportation

☐Ohio Department of Aging   ☐Community Health Accreditation Partner

☐The Joint Commission   ☐Local Public Children's Services Agency

☐Other: _____

*Critical Incident Category: (Please check the appropriate boxes as applicable.) *Answer option – multiselect*

Reminder to staff: Provide additional incident detail in the summary section below

☐Abuse: _____
   Specify what kind of abuse, such as physical, emotional, verbal, or sexual abuse, or the use of restraint, seclusion, or the use of restrictive intervention.

☐Neglect: _____
   Specify what kind of neglect, such as neglect by an individual other than the member or self-neglect?

☐Exploitation

☐Misappropriation Greater Than $500: _____
   Specify value of loss

☐Unnatural or Accidental Death

*Immediate Action for Health, Safety and Welfare: (Please check the appropriate boxes as applicable.)

Answer option – multiselect

☐EMS or medical attention   ☐Change in provider or services

☐Initiation of new services   ☐Referral to community resources

☐Location change   ☐Legal action

☐Other: _____

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*Incident Summary: (Please type a brief summary of the incident)

_____

_____

_____

_____

_____

_____

Incident Resolution: *(This section for Molina use only)*

Date incident closed: Click or tap to enter a date.

Was incident substantiated?   YES ☐   NO ☐