Health Home Incident Report

Washington State Health Care Authority

What is an incident?

In the context of this form, an "incident" is a negative event or occurrence which was not desired and/or anticipated, for which the care coordinator* was present or came into contact, or was otherwise made aware of.

1 Instructions

After an incident, the care coordinator* must report the incident to their supervisor and complete the first portion of the Health Home Incident Report form. Send a copy of the partially completed and signed form via secured e-mail to the contracted Health Home Lead Organization when this has been completed.

After the supervising organization portion of the form has been completed and signed, submit the form via the Health Care Authority's (HCA) Managed File Transfer (MFT), and send an email to the Health Home mailbox at **healthhomes@hca.wa.gov** when this has been completed.

Copies of the final completed form should be supplied to the Health Home care coordinator and maintained on file with care coordination organization and the qualified Health Home lead entity.

The completion of this form does not replace any required reporting to Adult Protective Services, Child Protective Services, Residential Care Services Complaint Resolution Unit, Department of Health, law enforcement, and/or other mandatory reporting agencies. Report abuse and neglect at: **www.dshs.wa.gov/report-abuse-and-neglect**

*Care coordinator, or other staff or volunteer, representing the care coordination organization or qualified Health Home lead entity.

2 Care Coordination Organization

Care coordinator _____ Care coordination organization _____

Qualified Health Home lead entity/Managed Care Organization _____

Date of incident _____ Time of incident: _____ ☐ A.M. ☐ P.M.

Location of Incident _____

Beneficiary involved in the incident (name and ProviderOne ID if available) _____ Date of birth _____

Briefly describe the incident. Attach additional pages if more space is needed.

Did the incident lead to injury ☐ Yes ☐ No Was first aid or medical attention required? ☐ Yes ☐ No

If first aid or medical attention was required, who provided the treatment?

Office/hospital

Names of witnesses and/or other individuals involved

Care coordinator signature

Date

3 Supervising Organization (Qualified Lead or Managed Care Organization)

Name of supervisor to whom this incident was reported

Care coordinator organization

Date of reporting

Time of reporting

☐ A.M. ☐ P.M.

List any planned actions including, but not limited to, training and policy initiatives. Attach additional pages if more space is needed.

Supervisor's signature

Date