

**OFFICE USE ONLY**

Time: \_\_\_\_\_ Rec'd By (initials): \_\_\_\_\_

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## SFCA UNINTENDED EVENTS REPORT

**Instructions:** This form must be completed in its entirety. This form is applicable to all members receiving services through the Southwest Family Care Alliance Managed Care Organization. Additional information may be attached to supplement information provided on the report form. Submit this form to the Quality Department within 24 hours of the incident. Additional material not available now may be sent at a later date. Completion of this form meets the requirements of the State/MCO contract as specified in the approved Southwest Family Care Alliance MCO Contract.

1. Date Form Completed (mm/dd/yyyy)	2. Name of Member's Care Managers	3. CMU
4. Report Type (Check all appropriate) <input type="checkbox"/> Unintended Event <input type="checkbox"/> Unexpected Death <input type="checkbox"/> Caregiver Misconduct		5. Target Group <input type="checkbox"/> FE <input type="checkbox"/> DD <input type="checkbox"/> PD
6. Type of Residence <input type="checkbox"/> AFH <input type="checkbox"/> CBRF <input type="checkbox"/> RCAC <input type="checkbox"/> Own Residence <input type="checkbox"/> NH		

**PERSON COMPLETING FORM / REPORTER INFORMATION**

7. Name - Last	8. Name - First
9. Title	
10. Name - Employer	11. Telephone Number

**MEMBER INFORMATION**

12. Name - Last	13. Name - First	14. MI
15. Address - (Street, City, State, Zip Code)		16. Telephone Number

**GUARDIAN INFORMATION (If applicable)**

17. Name - Last	18. Name - First
19. Telephone Number	

**CAREGIVER / PROVIDER INFORMATION**

20. Name - Caregiver	21. Name - Provider Agency
22. Address - Provider Agency (Street, City, State, Zip Code)	23. Telephone Number

**INITIAL REPORT**

24. Location of Incident	25. Date of Incident (mm/dd/yyyy)	26. Time of Incident (if known)
27. Provide a description of initial incident or allegation. Attach additional documentation, if necessary. Be sure to include names of persons involved.		

28. How did you learn of this incident?

29. Please provide a narrative describing the action taken and result of this incident.

30. Did member experience physical harm? <input type="checkbox"/> Yes <input type="checkbox"/> No	31. If Yes, please describe
32. Did member experience mental / emotional harm? <input type="checkbox"/> Yes <input type="checkbox"/> No	33. If Yes, please describe
34. Did the incident involve alleged abuse? Check all that apply: <input type="checkbox"/> Mental / Emotional <input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Verbal <input type="checkbox"/> Financial <input type="checkbox"/> OTHER	
35. Did the incident involve alleged neglect? Check all that apply: <input type="checkbox"/> Exposure <input type="checkbox"/> Failure to follow plan / poor care <input type="checkbox"/> Self-neglect <input type="checkbox"/> Medical / failure to seek <input type="checkbox"/> Nutrition <input type="checkbox"/> Unanticipated absence of provider <input type="checkbox"/> Medication error <input type="checkbox"/> OTHER	
36. Did the incident involve any of these other items? Check all that apply: <input type="checkbox"/> Unexpected serious illness / injury / accident <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Unanticipated absence of participant <input type="checkbox"/> Unexpected significant behavior, not addressed in a behavior support plan <input type="checkbox"/> Use of isolation/seclusion/restraint <input type="checkbox"/> Significant damage to property <input type="checkbox"/> Loss of property <input type="checkbox"/> OTHER	
37. Did the incident result in death? Check all that apply: <input type="checkbox"/> Accidental <input type="checkbox"/> Related to psychotropic medication <input type="checkbox"/> Related to restraint or seclusion <input type="checkbox"/> Related to suicide <input type="checkbox"/> OTHER _____	
38. Date of Death (mm/dd/yyyy)	39. Official cause of death (if known) as reported on the death certificate

**REPORTER CONTACT CHECKLIST**

40. Check all persons / agencies contacted by reporter.

- Adult Protective Services \_\_\_\_\_
- Care Manager (Required) \_\_\_\_\_
- Parent/Guardian (Required) \_\_\_\_\_
- Law Enforcement Agency \_\_\_\_\_
- Licensing/DQA \_\_\_\_\_
- Physician/Hospital \_\_\_\_\_
- Provider Agency \_\_\_\_\_
- Other, please specify: \_\_\_\_\_

Signed: (by reporter) \_\_\_\_\_ Date: \_\_\_\_\_