Effective: July 1, 2023

Submit this Form <u>AND</u> Complete AR DHS OLTC Incident Reporting Form DMS-7734 via secure email to: Incident.Reporting@CareSourcePASSE.com

* * * * * * * * * * * * * * * * * * * *

Member Information:

CareSource PASSE Member ID #:		Medicaid ID #:	
Member Home Address (Street, City, State, Zip):			
Member/Guardian Phone Number(s):			
Member Date of Birth:		Member Legal Status:	

Location of Incident and Involved Provider:

Location of Incident:	
Name and Address of Provider/Facility Involved in Incident or Responsible for Member at time of Incident:	

If Incident/Injury Required/Received Medical Attention:

Physician/Hospital Name:	
Physician/Hospital Complete Address:	
Physician/Hospital Phone Number:	
Disposition (Hospital Admission, Return to Facility, Referral to Another Provider, etc.):	

Roles and Names of Others Involved in Incident (*do not include identifying information about other residents***):**

Role (Relationship to Member	**Name (if employed by facility)**	**Complete Address and Phone**

Notifications:

Notified	**Name of Person/Agency**	**Contact Information**	**Method of Contact**	**Date of Contact**	**Time of Contact**
Adult Protective Services Hotline:		1-800-482-8049			
Child Abuse Hotline:		1-800-482-5964			
Parent/Guardian:					
Responsible Party (if different from Parent /Guardian):					
Law Enforcement:					
Other:					

Provider Findings/Outcome/Disposition (*When appropriate include corrective actions or preventive plans for future*)**:**

Investigation/Disposition Status		Description of Planned Investigation or Findings/Investigation/Outcome and Actions Taken
	Pending Investigation	
	Completed Investigation	

Incident Should/Could Have Been Prevented/Anticipated (*please explain*):

* * * * * * * * * * * * * * * * * * * *

Type of Report:

X	Type of Written Report	Date Report Written	Time Report Written	Date Report Submitted
	Initial Report			
	Follow-Up Report			
	Final Report			

* * * * * * * * * * * * * * * * * * * *

Report Submission by:

Person Submitting this Report:		Title:	
Email:		Phone Number:	
Facility Name:			
Facility Address:			

AR-PAS-P-2208981