**EXAMPLE CRITICAL INCIDENT REPORTING POLICY AND PROCEDURE**

Provider Name:

Disclaimer:  The Division of Healthcare Financing has provided the following policies as an example.  Providers may use this example as a starting point to develop policies that are specific to their circumstances.  Providers are obligated to follow the policies that they adopt.

If a participant experiences an incident that meets the Comprehensive and Supports Waiver critical incident reporting criteria, **[PROVIDER NAME]** will follow the incident reporting process outlined in Chapter 45, Section 20 of the Department of Health’s Medicaid Rules. After assuring the participant’s health and safety, **[PROVIDER NAME]** will contact the case manager and parent/legally authorized representative immediately, and submit a complete and accurate critical incident report at <https://www.wyoproviderportal.com/>. **[PROVIDER NAME]** will contact other agencies and meet appropriate timelines based on the table below.

|  | Division | DFS | P&A | Case Manager | Law Enforcement |
| --- | --- | --- | --- | --- | --- |
| **IMMEDIATE REPORTING** |
| Suspected abuse or self abuse  | X | X | X | X | X |
| Suspected neglect or self neglect  | X | X | X | X | X |
| Suspected abandonment  | X | X | X | X | X |
| Suspected exploitation  | X | X | X | X | X |
| Suspected intimidation  | X | X | X | X | X |
| Suspected sexual abuse  | X | X | X | X | X |
| Death  | X | X | X | X | X |
| **REPORTING WITHIN ONE (1) BUSINESS DAY** |
| Police involvement  | X |  | X | X |  |
| Restraint usage  | X |  |  | X |  |
| Injuries caused by restraints  | X |  | X | X |  |
| Seclusion  | X |  | X | X |  |
| Serious injury to the participant | X |  | X | X |  |
| Elopement  | X |  | X | X |  |
| Medication errors that result in emergency medical attention | X |  | X | X |  |
| Medical or behavioral admission or emergency room visit that isn’t a scheduled medical visit  | X |  | X | X |  |
| A significant risk to a participant’s health and safety  | X |  |  | X |  |
| Medication errors, including wrong medication, wrong dosage, wrong route, wrong time, or a missed medication **(Medication errors shall be reported within three (3) business days)** | X |  |  | X |  |

**[PROVIDER NAME]** will maintain incident reports for all critical incidents, and will review all incident information as described below.

**[PROVIDER NAME]** will collect information about incidents that occur following the described process: (i.e., preceeding events, follow up conducted..):

[Provider Name] will use the data collected to decrease similar incidents in the future by: (describe how often data will be analyzed, how action steps will be determined)

*I certify I will follow the policy and procedures noted above. I understand that failure to follow this policy is a violation of Department of Health Medicaid Rules, and may result in adverse action pursuant to Chapter 45.*

**Provider Name:**

**Signature: Date:**

**FOR REFERENCE**

Division of Healthcare Financing contact:

Local Department of Family Services (DFS) office:

Protection & Advocacy (P&A): Office – (307) 632-3496, Fax – (307) 638-0815, Email – incidents@wypanda.com

Local law enforcement non-emergency contact: