Coordinated Care of Washington, Inc. External

Critical Incident Notification Form 2020

***Required Field**

Member Information

***Member Name (Last, First MI)**

***Member DOB**

***Provider One Number**

Incident Information

***Date of Incident** ***Date of Discovery**

Facility (BH facility, FQHC, or Independent Health Provider if applicable; provide brief description and all individuals involved)

***Staff Reporter (Name, title, facility, contact number)**

☐ ***Member has documented Behavioral Health diagnosis**

***Type of Incident**

***Location of Incident**

***Facility (Provide a brief description and all individuals involved)**

***Description of Incident (Limit 750 characters)**

***Disposition**

- ☐ In Jail
- ☐ Inpatient
- ☐ Inpatient Psychiatric
- ☐ Inpatient SUD
- ☐ Discharged Home
- ☐ Unknown at the time of this submission
- ☐ Other

***Notification (Select all that you initiated)**

- ☐ Police
- ☐ CPS/APS
- ☐ DOH (outbreak/exposure events)
- ☐ DCYFS
- ☐ Family Notified
- ☐ Medicaid Control Fraud Unit
- ☐ Aging and Long-Term Support Administration (Residential Care Services)
- ☐ Other

Attestation

☐ *The submitter attests that the information being submitted has been verified as true and accurate.

***Document completed/submitted by (Name, title, facility, and date)**

Submit this form to:

CI Inbox: WA_QOCCI_REPORTING@CENTENE.COM

CI Fax: 866-270-1885