

Critical Incident Reporting Line: (888) 210-2705

Critical Incident Report Form			
Member name:		Contact number:	
Member ID:	LOB:	Is member receiving: CBAS IHSS NF MSSP	
Date of Incident:		Time of Incident:	AM PM
Location of Incident (include address):			
Name of person completing form:			
Position/Occupation:		Contact number:	
Names of health plan/IPA employees or volunteers involved in incident		Contact number	
1:			
2:			
3:			
Names of additional parties involved		Contact number	
1.			
2.			
3.			
4.			
Description of Incident and Background (include all relevant circumstances leading up to the incident, whether the incident was witnessed, etc.):			

Who else was informed of the incident? Include names (APS, DCFS, Ombudsman, County Mental Health Services, police, fire department, family members, etc.):

Actions taken to date (include details like date and time, names, contact numbers, and specific supports or referrals provided, and members response):

Follow up actions planned:

Fax completed form to (323)889-2109

Critical Incident Report form reviewed by:

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(Signature of employee)

(Date: mm/dd/yyyy)

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(Signature of manager)

(Date: mm/dd/yyyy)