Health Homes of Upstate New York

Incident Reporting Form

Date and Time Recorded by HHUNY ________________ Recorded By: ____________________________

Please complete and submit through secured/encrypted e-mail to the HHUNY Incident Reviewer: lspas@hhuny.org

Care Management Agency: ________________________________

Reporter Name: ________________________________

Reporter Phone ________________________________

Reporter Email: ________________________________

Health Home:

Member Name: ________________________________

Member CIN ________________

Member DOB ________________ Member Date of Death ________________

Date Reported ________________

Member Enrolled Date ________________

Pertinent Diagnoses:

Date of Last Contact Prior to Incident: ________________

Description of Last Contact:

Member's Current Location: ________________________________

Is Member Safe? Yes No

Incident Type:

Date and Time Incident Occurred: ______________________________

Date and Time of Discovery: ______________________________

Incident Description:

Was there Media Coverage? Yes No

If yes, indicate source:

Immediate action taken to protect, support or link member to services