

**For DOH Use Only:**

Incident Number:

DOH Reviewer:

**Health Home Incident Reporting Form**

Please complete form with accurate and complete information and submit to Lauren Schultz (lzs01) via the Health Commerce System. Any questions regarding the Health Home Incident Reporting Policy or Procedure can be directed to [HHRedesignation@health.ny.gov](mailto:HHRedesignation@health.ny.gov).

**Health Home Information**

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Health Home:

Care Management Agency:

Reporter Name:

Phone:

Email:

Date Reported:

**Member Information**

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Member Name:

Member CIN:

Member Enroll Date:

Member DOB:

Pertinent Diagnoses:

Date of Last Contact Prior to Incident:

Description of Last Contact:

Member's Current Location:

**Incident Information**

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Incident Type:

Date and Time of Occurrence:

Date and Time of Discovery:

Incident Description:

Media Coverage?      Yes      No      If yes, indicate source:

Immediate action taken to protect (reports investigative protection agencies), support or link member to services based on the current system: