♦Department of Human Services ♦Social Services Division ♦Adult and Community Services Branch♦
Medicaid Waiver Programs

Report of Adverse Events

Contract Provider must call Case Manager (CM) within 24-hours, and send this completed form to CM and DHS-MWS within 72 hours of the adverse event. Attach another sheet if needed. TYPE or PRINT, this document must be legible.

Contract Provider Name:

Name and Position of individual reporting the adverse event:

Phone:_____

When did adverse event occur?
Date:
Time: ☐AM ☐PM

Client Name:

Date of Birth or SS number:

Location where adverse event occurred: ***(Check one)*** Client's ☐
Address: Agency's ☐
Phone number: Other_____ ☐

Case Management Unit or Contractor:_____

Case Manager:_____

Type of Adverse Event:

☐ Bodily Injury ☐Fall with No Injury ☐Fall with Injury ☐Fall with Medical Treatment ☐Pressure Ulcer
☐Medication Error ☐Emergency Room Visit ☐Hospitalization ☐Elopement ☐APS/CPS Involvement
☐Death ☐Other

Description of the reported adverse event, include any witnesses :

Contract Provider action taken as a result of the reported adverse event, include any measures taken to protect clients:

For CM staff:

Verbal Report received by:_____ (Name) on _____ (Date) at _____ (Time) AM/PM (Circle One)

Written Report received by:_____ (Name) on _____ (Date) at _____ (Time) AM/PM (Circle One)

Describe action taken (including service plan changes), if any, as a result of the reported adverse event:

Reported to: ☐APS ☐CPS ☐Other Agency(ies):_____ (Agency Name(s))

Signatures: _____ (Case Manager Signature) _____ (Date) _____ (Supervisor Signature) _____ (Date)

For DHS/MWS & ACCSB-PD staff:

Written Report received by:_____ (Name) on _____ (Date) at _____ (Time) AM/PM (Circle one)

Route to: Y _____ (MWS-CMU) Y _____ (ACCSB-PD) Y _____ Y _____