♦ Department of Human Services ♦ Med-QUEST Division ♦

☐ **Adverse Event Report** ☐ **Change in Member Condition**

ALL ISLAND CASE MANAGEMENT CORPORATION

Contract Provider must call Community Care Manager Agency (CCMA) or Service Coordinator (SC) within 24-hours, and send this completed form to CCMA/SC and QI Health Plan within 72 hours of the adverse event. Attach another sheet if needed. TYPE or PRINT, this document must be legible.

Contract Provider Name:

Facility Name (as applicable):

Name and Position of individual reporting the adverse event or change of condition:

Person Completing Report: ________________________________ Check: ☐ PCG ☐ SCG

Phone:________________________

When did adverse event/condition occur?

Date: ____________________

Time: _____________ ☐ AM ☐ PM

PARTICIPANT NAME: ____

☐ Medicaid ☐ Private Medicaid ID#: 000______________________

Date of Birth: ____________________ QI Health Plan: ___________

Diagnosis:

____

Location where adverse event occurred: (***Check one***)

☐ Home ☐ EARCH/CCFFH

Address: ____

City: ____________________ State: HI Zip Code: ________

Phone #: __________________________

CMA Name: ***ALL ISLAND CASE MANAGEMENT CORPORATION***

RN Case Manager: _____________________________________

Event Type: (check all that apply) Injury☐ Fall ☐ ER☐ Hospital☐ Medication Error☐ Service/Staffing ☐ Elopement ☐ Environment ☐ Transportation☐ Criminal☐ Death☐

Description of the reported adverse event or change of condition:

Contract Provider action taken as a result of the reported adverse event or change of condition:

☐ Participant's Family/Guardian notified (as applicable) ____________________________ Date: ________________ Time: ___________

Name of Physician notified: ___________________ __________ ___________________ Date: __________________ Time: ____________

Physician action taken/ orders as a result of the reported adverse event. or change of condition)

For CCMA/SC 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***)

☐ HOME VISIT WITH ASSESSMENT for change in condition (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 or change of condition event:

Reported to: ☐APS ☐CPS ☐Community Ties of America ☐ QI Health Plan ___________________ ☐ GHP

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

For CTA/QI Plan/GHP staff:

Written Report received by: ____ (Name) on ______________ (Date) at _______________ (Time) AM/PM (***Circle one***)