MyCare Ohio Incident Report Form

Anthem Blue Cross and Blue Shield | MyCare Ohio

Section 1: Reporter Information	
Reporter's first name	
Reporter's last name	
Organization	
Job title	
Phone number	
Date of report	

Section 2: Member Information	
Member's first name	
Member's last name	
DOB	
Member ID	
Member street address	
City	
State	
ZIP code	
Phone number	

Section 3: Other Contacts	
☐ Authorized representative	
☐ Guardian	
☐ Power of attorney	
☐ Care coordinator	
☐ Waiver service coordinator	
☐ Specialized recovery services (SRS) recovery manager	
☐ Home choice transition coordinator	
First name	
Last name	

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Contact number	

Section 4: Preliminary Information (Incident Location)	
Location name	
Street address	
City	
State	
ZIP code	

Section 5: Type of Incident
This is a **critical incident** related to:
☐ Abuse
☐ Neglect
☐ Exploitation
☐ Misappropriation
☐ Unnatural/accidental death
☐ Self-harm or suicide attempt
☐ Individual is at risk due to being lost or missing
☐ Prescription medication issue
This is a **reportable incident** related to:
☐ Natural death
☐ Creation or adjustment to a health and safety action plan (HSAP)
☐ Health and welfare of the individual is at risk due to loss of caregiver, medication issue, eviction, or housing crisis
☐ Loss of the individual's paid or unpaid caregiver
☐ Prescribed medication issue not resulting in EMS response, emergency room visit, or hospitalizations
☐ Eviction or housing crisis
☐ Suicide attempt not resulting in emergency room treatment, inpatient observation, or hospital admission

Section 6: Incident Date and Category	
Date of incident	
Select the incident category	
☐ Member abuse	
☐ Physical	
☐ Emotional	
☐ Sexual	
☐ Neglect	
☐ Self-harm	
☐ Self-neglect	
☐ Suicide attempt	
☐ Exploitation	
☐ Individual lost or missing	
☐ Misappropriation	
☐ Prescription medication	
☐ Provider error	
☐ Member	
☐ Unnatural or accidental death	
☐ Natural death	
☐ HSAP creation or adjustment	
☐ Welfare risk categories	

Section 7: Incident Details	
Is the member subject to further harm?	☐ Yes ☐ No
Do you have further emergency needs at this time?	☐ Yes ☐ No
Was the incident reported in the media?	☐ Yes ☐ No
Describe the incident:	

Section 7: Incident Details
Describe the incident, cont.

Section 8: Alleged Person(S) With Information	
First name:	
Last name:	
Relationship to member:	
Provider/agency name (if applicable)	
Phone number:	
Email address:	
Street address:	
City:	
State:	
ZIP code:	
Second alleged person, if needed	
First name:	
Last name:	
Relationship to member:	
Provider/agency name (if applicable)	
Phone number:	
Email address:	
Street address:	
City:	
State:	
ZIP code:	

Section 9: Actions Taken	
☐ Were any of the following actions taken?	
☐ EMS or medical attention	
☐ Change in provider or services	
☐ Initiation of new services	

Section 9: Actions Taken
☐ Referral to community services
☐ Removal of environmental barriers
☐ Location change
☐ Legal action
☐ Other
☐ No action taken

Section 10: Notified External Agencies
☐ Coroner's office
☐ Law enforcement
☐ County Board of Developmental Disabilities
☐ Public Children Services Agency (PCSA)
☐ State Long Term Care Ombudsman
☐ Alcohol, Drug Addiction, and Mental Health Services Board
☐ The Ohio Department of Health
☐ Other (specify)
☐ No agencies were notified

Upon completion of this form, email to MyCareIncident@anthem.com.