New York State Department of Health
Division of Home and Community Based Services

SERIOUS REPORTABLE INCIDENT
PROVIDER INITIAL REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
TRAUMATIC BRAIN INJURY (TBI)

RRDC Region: _____

Participant Name: _____ CIN: _____

Address: _____

_____ Phone: _____

Discovery Date and Time: ___/___/_____ am/pm Name of person discovering alleged incident: _____

Relationship to Participant: _____:

Date and Time alleged incident occurred: ___/___/_____ am/pm

Preliminary category of alleged incident:

☐ 1. Abuse/Neglect
☐ 2. Missing Person
☐ 3. Restraint
☐ 4. Death of Participant
☐ 5. Hospitalization
☐ 6. Possible Criminal Act
☐ 7. Medication Error/Refusal
☐ 8. Medical Treatment Due to Accident or Injury
☐ 9. Sensitive Situation

Describe the alleged incident (include the location where it occurred, any person(s) present at the time, and the circumstances). Include only known facts.

Describe waiver participant's current condition/status and current location:

List any person(s) alleged to be involved in incident:

Describe any actions taken to assist the waiver participant:

Name of Waiver Staff first notified, if not discoverer: _____ Title: _____

Report completed by: _____ Title: _____

Reporting Agency: _____ Telephone: _____

Date and Time copy of report sent to RRDS: ___/___/_____ am/pm Name of RRDS: _____
Date and Time copy of report sent to SC: ___/___/_____ am/pm Name of SC: _____