♦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: Phone:___(808)_____)	When did adverse event/condition occur? Date: Time: ☐AM ☐PM
PARTICIPANT NAME: Medicaid #: Date of Birth: QI Health Plan_____ Diagnosis:	**Location where adverse event occurred:** ***(Check one)*** Home ☐ Address: EARCH/CCFFH ☐ Phone number: Other_____ ☐
CMA Name: ***ALL ISLAND CASE MANAGEMENT CORPORATION*** Case Manager/Service Coordinator:_____	**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)