Critical Incident Report Form

Please complete and submit this form to UnitedHealthcare Community Plan of Minnesota:

Submit this form by: Email: critical_incidents@uhc.com | Fax: 855-371-7638

If you need assistance completing the form, please contact your provider advocate or email us at critical_incidents@uhc.com. Thank you.

Member's name:

Member's UnitedHealthcare Community Plan ID number:

Member's address:

Member's Medicare ID number:

Member's date of birth:

Member's UnitedHealthcare Community Plan benefit plan (choose 1):

- ☐ Minnesota Senior Health Options (MSHO) Dual FIDE-SNP
- ☐ Minnesota Senior Care Plus (MSC+) Medicaid/LTSS
- ☐ Minnesota Special Needs Basic Care (SNBC) – Integrated Dual FIDE SNP
- ☐ Minnesota Special Needs Basic Care (SNBC) – Non-Integrated Medicaid/LTSS

Choose the type of incident (choose 1):

- ☐ Suicide (intentionally killing oneself)
- ☐ Attempted suicide (the attempt to intentionally kill oneself, and the attempt caused injury or could have resulted in serious injury or death)
- ☐ Death (accidental death, death from natural causes or homicide)
- ☐ Assault (act of aggression by or to a recipient that results in serious injury)
- ☐ Alleged maltreatment (alleged maltreatment)
- ☐ Serious injury (any injury to a recipient that requires hospitalization or significant medical treatment.
  - Treatment that could not be provided by a trained health care person in a non-clinic setting, such as treatment provided by the program's registered nurse (RN)
  - A report is not required if the recipient was evaluated by a health care person to rule out a fracture or other serious injury, when it was determined there was no fracture or other serious injury
- ☐ Other (other significant incidents that require the program to take an action that's not part of the program's ordinary daily routine)
- ☐ Other act or situation that requires a response by law enforcement, fire, ambulance, etc.
  - Reports aren't required if law enforcement is only contacted as an alert to a recipient who walked away and doesn't request a response

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Describe the incident (attach another sheet if necessary), including who, what, when, where, why and how. Do not include opinions, just state the facts.

Describe any actions taken as a result of the incident. Summary of program's response.

Name of the person who first became aware of the incident and their relationship to the member:

Where did the incident occur (choose one)?

- ☐ Family home
- ☐ Group home or assisted living facility
- ☐ Medical facility
- ☐ Nursing facility
- ☐ School
- ☐ Place of employment
- ☐ Other (please describe):
- ☐ Intensive residential treatment facility

Incident date: | **Incident time:**

Was the incident reported to local emergency authorities, licensing agency, case manager, police/sheriff, parent, other? ☐ Yes. When? ☐ No

Attachments: ☐ Yes ☐ No

Your name:

Your relationship to the member:

Your or your agency's tax ID number (TIN):

Your or your agency's email address:

Which best describes you or your agency?

- ☐ Long-term services and supports (LTSS) (please describe below)
- ☐ Primary care provider
- ☐ Specialty provider (please describe below)
- ☐ Intensive residential treatment facility
- ☐ Other (please describe below)

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