STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR SOCIAL SERVICES
Office of Policy and Programs
Division of Regulatory Management
BSSCriticalIncident@wv.gov

CRITICAL INCIDENT REPORT FORM

This form must be submitted within **72 hours** of notification of a **Critical Incident to BSSCriticalIncident@wv.gov.**

All incidents must be verbally reported within **24 hours to the Department caseworker and the MCO**.

NOTE: A critical incident is an alleged, suspected, or actual occurrence of an incident that can reasonably be expected to result in harm to a participant; and includes abuse, neglect, or exploitation, suicide or attempted suicide, homicide, death of a resident, injury that requires medical treatment or hospitalization, fire resulting in injury or a fire department response, runaway or missing child. life-threatening reaction because of a drug or food, a medication error resulting in emergency medical care, a natural disaster, incidents that require client evacuation from the building or a medical outbreak.

RESIDENTIAL PROVIDER INFORMATION

Facility Name: _____ **Phone:** _____

Address: _____
Street Address

_____ _____ _____
City *State* *ZIP Code*

CLIENT INFORMATION

Full Name: _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female ☐ Other

NOTIFICATIONS

Individual/Entity Receiving Notification	Notification Method / Date/Time
☐ Parent, Legal Guardian or Representative ☐ Person/Agency:	
☐ Abuse/Neglect Referral (CPS/APS) Referral #:	
☐ Sending State Case Worker ☐ Person:	
☐ Medical Professional ☐ Person/Agency:	
☐ Law Enforcement ☐ Person/Agency:	
☐ Other:	

INCIDENT DETAILS

Date/ Time of Incident: ☐ am ☐ pm **Supervisor on Duty:**

Type of Incident (Check all that apply)

- ☐ Abuse, Neglect or Exploitation
- ☐ Death (due to any cause)
- ☐ Suicide or attempted suicide
- ☐ Fire resulting in injury and/or fire department response
- ☐ Medical Outbreak
- ☐ Any involvement with Law enforcement
- ☐ Injury requiring medical attention or hospitalization
- ☐ Medication error resulting in emergency medical care
- ☐ Natural disaster
- ☐ Client evacuation from the building
- ☐ Runaway or missing child
- ☐ Life-threatening reaction because of a drug/food
- ☐ Other:

Describe circumstances or events leading up to the incident.	
Describe the incident in detail. Identify and detail the precise location, including the area of the facility/community.	
Describe actions taken in response to the incident, including all client remediation efforts.	
Describe follow-up plans, including all actions necessary/taken to prevent similar future incident and person responsible for implementation.	
Detail all medical services performed on-site and off-site (prior to, during, and post-event). Include contact information for medical professionals/offices rendering services to the client.	

Please list names of staff involved and witness.	
Include any additional information not addressed elsewhere but pertinent to the incident.	

SIGNATURE AND CERTIFICATION STATEMENT

I, the undersigned, certify that the above information is true, accurate, and complete to the best of my knowledge. I understand that any misrepresentation or concealment of any information required in this report may subject me and/or other individuals, partnerships, corporations, or organizations operating the program to liability under civil and criminal laws.

Individual First Name (Print) *Middle Name* *Last Name (Print)*

Individual Signature (First and Last Name) *Date Signed (mm/dd/yyyy)*

Title of Signatory *Email*

REPORT SUBMISSIONS

Send the completed "Critical Incident Report Form" via email to BSSCriticalIncident@wv.gov. Please include additional pages as necessary to sufficiently address incident reporting requirements and include all pertinent medical evaluation documents referenced.