APPENDIX F
INCIDENT REPORT FORM

Please send by secure email to MassHealth Office of Behavioral Health

Adverse Incident Report

Notifications: ☐ (Contractor's Name) ☐ DMH ☐ DCF ☐ DYS ☐ DPPC ☐ DDS ☐ Other

Client: **Social Security** #:

☐ **M** ☐ **F** **DOB**: **Age**:

Facility: **Unit**: **City**:

☐ **24-hour facility** ☐ **Non 24-hour facility**

Date and Time of Incident: mm/dd/yyyy@hh:mm

Date and Time of Discovery: mm/dd/yyyy@hh:mm

Type of Incident:

Describe Incident. If AWA, please include search, notification and commitment status:

Describe Immediate Response to the Incident:

Restraints Used? ☐ None ☐ Mechanical ☐ Chemical ☐ Physical **Time in Restraints**:

Please Check if Recommended: ☐ Internal Investigation ☐ Policy and Procedure Review ☐ Staff training ☐ Disciplinary action to staff

☐ **Please check if additional information is attached.**

Person Reporting: **Telephone #**:

Signature: **Date:**

MassHealth Office of Behavioral Health

Please send by secure email

Appendix A, Exhibit BH-1

Behavioral Health Adverse Reportable Incident - Daily Roster

Health Plan Name: _____

Date: _____

Please see DMH requirements for Restraint and Seclusion at 104 CMR 27

**** For complete list of BH covered services see plan's contract***

Please note that the shaded columns, starting with row 21 there is a drop down menu. For a full list of options, please see Key tab.

Behavioral Health AIs by Facility, Gender, Service, Age, Type

Facility	Date Received by Plan	Date of Incident	Gender	* Service	AGE Group	Plan's Incident ID code for member	Type of Incident	Type of Incident if Other, briefly describe