DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-22541 (07/2020)

STATE OF WISCONSIN
Completion of this form meets the requirements and conditions of the CMS-approved Medicaid Waiver programs

INCIDENT REPORT – IRIS

Instructions: This form may be completed in stages but must eventually be completed in its entirety. It is applicable to all participants receiving services through the IRIS program. Additional information may be attached to supplement but not replace information provided on the report form. This form must be uploaded to the participant's WISITS document library, as well as entered and saved in your agency's Critical Incident site on SharePoint. Failure to report incidents as required or in a timely manner may result in issuance of an improvement plan, corrective action, and/or negative findings in the record review process for the IRIS consultant agency.

TIMELINES: If a Critical Incident, report to waiver agency WITHIN 24 HOURS. Agencies: Notify state contact staff within THREE BUSINESS DAYS of the initial report.

PARTICIPANT INFORMATION

1. Name – Last		Name – First	MI
2. Address – Street (Participant)		City / State / Zip Code	
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Telephone Number	
6. Name – Residential Service Provider		Address – Residential Service Provider	
7. County of Physical Residence		8. County of Fiscal Responsibility	
9. MCI Number			

INCIDENT INFORMATION

11. Date of Event	12. Location Event Occurred (Street, City, State, ZIP Code)
13. Name – Reporting Provider (Individual / Agency)	Reporting Provider Contact Information (Telephone No., Email)

14. **Type of Report** (Check all that apply)
☐ Critical ☐ Original ☐ Update ☐ Correction ☐ Incident Review Completed and Closed

15. **Type of Setting Where Incident Likely Occurred**

Residence
☐ Natural or adoptive home (with parents)
☐ Person's own home
☐ Adult family home, 1-2 bed
☐ Adult family home, 3-4 bed
☐ CBRF

Other
☐ School
☐ Child care center
☐ Work site in community
☐ Work site—congregate vocational provider
☐ Day activity site
☐ Day treatment program
☐ Community Setting—park, store, etc.
☐ Respite provider site
☐ Another person's residence
☐ Waiver transportation provider, public
☐ Waiver transportation provider, agency or individual
☐ Public transportation provider- not waiver funded
☐ Other – Specify:

EVENT / ALLEGATION CHECKLIST

16. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is uncertainty about whether the event occurred.

Event Type / Allegation	Alleged Only	Event Type / Allegation	Alleged Only
Abuse		Neglect (Cont'd)	
☐ Mental / emotional	☐	☐ Medical / failure to seek	☐
☐ Physical	☐	☐ Nutrition	☐

- ☐ Sexual ☐
- ☐ Verbal ☐
- ☐ Misappropriation of the person's funds or property ☐

Death

- ☐ Accidental ☐
- ☐ Anticipated ☐
- ☐ Unanticipated ☐
- ☐ Related to psychotropic medication* ☐
- ☐ Related to restraint or seclusion* ☐
- ☐ Related to Suicide* ☐

NOTE: *Deaths related to above factors in a licensed or certified facility must be reported to the Department Death Review Committee within 24 hours.

Law Enforcement Related

- ☐ Commission of crime ☐
- ☐ Victim of crime ☐
- ☐ Arrest or incarceration ☐

Neglect

- ☐ Environmental ☐
- ☐ Fail to follow plan / poor care ☐
- ☐ Unsafe or unsanitary environmental conditions ☐
- ☐ Self-Neglect ☐
- ☐ Unanticipated absence of provider ☐
- ☐ Error in medication resulting in significant reaction requiring medical attention ☐

Other

- ☐ Unexpected serious illness / injury / accident ☐
- ☐ Unexpected, untimely, urgent, emergency hospitalization ☐
- ☐ Overdose of drugs or alcohol **by participant** ☐
- ☐ Unexpected significant behavior, not addressed in a behavior support plan ☐
- ☐ Emergency / unplanned use of isolation/seclusion / restraint ☐
- ☐ Misuse of restraint or other restrictive measure ☐
- ☐ Suicide attempt ☐
- ☐ Significant damage to property ☐
- ☐ Fire ☐
- ☐ Unanticipated absence of participant ☐
- ☐ Other—Please describe ☐

17. Provide Brief Description of incident:

18. Describe action taken to date as a result of the incident to resolve incident and assure health and safety of participant:

IF THE PARTICIPANT DIED, COMPLETE THE FOLLOWING:

19. Date of Death	20. Official cause of death as reported on the death certificate

CONTACT / SUPPLEMENTAL REPORTING CHECKLIST

21. Check all persons / agencies contacted by IRIS consultant agency

- ☐ A. Child Protective Services
- ☐ B1. Adult Protective Services
- ☐ B2. Wisconsin Incident Tracking Report Submitted
- ☐ C. CSS / Children's Services Specialist (Required for CLTS Waiver)
- ☐ D. IRIS Independent Consultant
- ☐ E. Parent / Guardian (Required)
- ☐ F. Law Enforcement Agency
- ☐ G. Licensing Agency
- ☐ H. Physician
- ☐ I. Provider Agency
- ☐ J. DHS Waiver Manager / Central Office
- ☐ K. Caregiver Misconduct Statewide Complaint Hotline: 800-642-6552
- ☐ L. Other—Specify:
- ☐ M. Note any person / entity **NOT notified** and why:

22. Was the perpetrator / alleged perpetrator a paid service provider for subject of incident or was he/she an unpaid provider?
☐ Paid provider ☐ Unpaid Provider ☐ NA

23. Name – Caregiver involved where incident occurred.

24. Name – Employer of the caregiver involved when incident occurred

25. Address of Provider Agency employing the caregiver (Street, City, State, Zip Code)

OUTCOME AND CONCLUSION

26. Please provide a detailed description of the significant actions and events (e.g., staff terminated, arrested, etc.; person treated at ER) taken by all parties involved and their effects following the incident.

27. Please discuss changes to the waiver participant's situation or status as a result of the incident including revisions to the person's individualized service plan, provider/staff, living arrangement, school, work, guardian, etc., and how these changes assure the participant's safety and improve his/her quality of life.

28. Type of change made or action taken by IRIS consultant agency or contractor as a result of Incident (check all that apply)

a. ☐ Nothing changed
b. ☐ Corrective action initiated
c. ☐ Terminate staff
d. ☐ Change in personnel working with the participant
e. ☐ Added staff coverage
f. ☐ Change agency that provides service
g. ☐ Change to Individualized Service Plan
h. ☐ Added new service
i. ☐ Reduced service
j. ☐ Terminated service
k. ☐ Increased amount and/or type of external monitoring of setting
l. ☐ Medically related consult
m. ☐ Behavioral consult
n. ☐ Staff providing training related to subject of incident
o. ☐ Refer to Licensing (Children's)
p. ☐ Refer to Licensing (Adult)
q. ☐ Report to CPS
r. ☐ Report to APS
s. ☐ Report/Refer to caregivers
t. ☐ Refer to Disability Rights Wisconsin
u. ☐ Refer to District Attorney/law enforcement agency
v. ☐ Other – Specify: _____

NOTIFICATION OF INCIDENT

29. Date Form Completed	30. Name – Primary IRIS Consultant.

31. Date of initial notification

32. Original Reporter:

☐ Participant
☐ Parent
☐ Staff in Provider Agency
☐ Support and Service Coordinator / Broker
☐ State / County Licensing or Certification Staff
☐ Anonymous Complaint
☐ Other Community Member
☐ Guardian (Can check other choices if this choice is checked)
☐ Other Family Member
☐ Staff in other Provider Agency
☐ IRIS Consultant (IRIS only)
☐ Other Governmental (e.g., law enforcement)
☐ Independent Provider / Non-Agency Staff
☐ Other: Specify: _____

PERSON COMPLETING FORM INFORMATION

33. Name – Last	Name – First
34. Title	Name of Agency

35. Email Address	36. Telephone Number

SUPPORT & SERVICE COORDINATOR / INDEPENDENT CONSULTANT / BROKER INFORMATION (If different from above)

37. Name – Last	Name – First	38 Telephone Number

39. Email address

SIGNATURE – Person Reporting | **PRINT** Name | Date Signed