COLORADO
Department of Health Care Policy & Financing

HCBS Provider Critical Incident Follow-Up Form

Today's Date: _____

Provider Name: _____

Provider Agency: _____

Case Manager Name: _____

Case Management agency name: _____

Date of Incident: ____/____/____

Client Name: _____

Medicaid ID #: _____ DOB: _____/____/_____

HCBS Waiver program client is enrolled in: _____

Describe follow-up actions taken in response to incident: _____

_____

_____

_____

_____

_____

_____

Was an investigation of the incident conducted by the provider/provider agency?

☐ Yes ☐ No

If applicable, describe the investigation and findings: _____

_____

_____

_____

_____

_____

Are there additional actions that should be taken to resolve the incident/situation? ☐ Yes ☐ No

If yes, what additional actions need to be completed?

What can be learned from this incident to prevent and/or avoid future occurrences?

What procedural changes will be made by the provider and/or agency to prevent and/or avoid similar incidents in the future?