ARKANSAS PASSE Incident Report Form

Type of Report	☐ **Initial Written**	**Date/Time:** _____
	☐ **Follow-Up**	**Date:** _____
	☐ **Final**	**Date:** _____

☐ **APC LLC** (DBA Summit) 1-844-462-0022 ArkansasQuality@anthem.com
☐ **Empower** 866-261-1286 Incident.Reporting@empowerhcs.com
☐ **Arkansas Total Care** 866-282-6280 Incident@ArkansasTotalCare.com

Incident Date: _____ Incident Time: _____
Injured Person's Name: _____
Address: _____
Phone Number(s): _____
Age or Date of Birth: _____
Gender: _____ Race: _____
Legal Status: _____

Incident Type:
☐ Death; Suspected Cause? _____
☐ Suicidal Behaviors ☐ Rape
☐ Maltreatment/Abuse/Exploitation:
☐ Neglect ☐ Verbal ☐ Physical ☐ Sexual ☐ Other; _____
☐ Missing Client ☐ Injury ☐ Disturbance ☐ Property Destruction ☐ Theft ☐ Arrest
☐ Other; _____

Does Incident/Injury Require Medical Attention? ☐ Yes ☐ No
Physician/Hospital Name: _____
Address: _____
Phone Numbers: _____

Designation of Incident:
☐ Member to Member ☐ Member to Staff ☐ Self-inflected ☐ Member to Public ☐ Public to Member
☐ Other; _____

Roles (Relationship to Subject) and Names of Others Involved:

Role	Name	Address and Phone

(Continue, if needed, in the Additional Information as Needed section, on the next page.)

Notifications (Enter method, date and time when communicated as appropriate.)
☐ Adult Protective Services Hotline (1-800-482-8049): _____
☐ Child Abuse Hotline (1-800-482-5964): _____
☐ DHS PASSE Incident report line (501-371-1329 Fax 501-371-1474): _____
☐ DHS PASSE Ombudsman: _____
☐ Next of Kin: _____
☐ Responsible Party (if different from above): _____
☐ Law Enforcement: _____
☐ Other: _____

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	☐ **Final**	**Place of Incident: _____**

Clear, Concise Description of Incident:

Should/Could Incident Have Been Prevented/Anticipated? ☐ Yes ☐ No (If yes, please explain.):

Findings/Outcome/Disposition (When appropriate include corrective action or preventive plans for future.)

☐ Pending Investigation

☐ Investigated with Appropriate Action/Preventive Plan Attached

Additional Information as Needed:

Person Submitting Form: _____ Title: _____
PASSE: _____ Phone Number: _____ Email: _____
HCBS Provider: _____ Contact: _____
Phone Number: _____ Email: _____