MISSISSIPPI DIVISION OF MEDICAID

Office of Mental Health Programs
550 High Street, Suite 1000
Jackson, MS 30201
601-359-9545
FAX: 601-359-6294

Psychiatric Residential Treatment Facility (PRTF)
Incident Report Form – Confidential

Please submit completed form via EMAIL to MSPRTF@TELLIGEN.COM

SECTION I – REPORTING FACILITY AND REPORTING PERSON

PRTF Name:	Form Completed By:
Address:	Title: Investigator
City, State, ZIP:	Phone Number:
Risk Manager:	Case # (if applicable):
Phone Number:	Date faxed to DOM:

SECTION II – RESIDENT INFORMATION

Indicate if the resident/s involved are MS Medicaid beneficiaries and list their name/s below. List only the initials of any non-MS Medicaid residents.

☐ MS Medicaid Beneficiary ☐ Non-MS Medicaid Beneficiary

Resident Name/Initials:

VICTIM:

SUSPECT:

SECTION III – INCIDENT INFORMATION

Date Incident Occurred:

Date Resident Reported to Staff:

Day of Week Incident Occurred: __M ___T __W __TH ___F ___S __SU

Type of incident (Check all that apply):

☐Serious Injury/illness requiring attention by in-house medical staff
☐ Serious Injury/illness requiring outside medical attention
☐ Injury resulting from physical restraint/seclusion
☐ Harm to self
☐ Physical assault by resident
☐ Sexual contact by residents
☐ Sexual assault
☐ Contraband found that could cause harm (illegal substances, lighter, etc.)
☐ Substance use on facility grounds/supervised trip
☐ Elopement
☐ Medication error requiring medical attention
☐ Suicide Attempt
☐ Suicide
☐ Mistreatment or allegations of mistreatment including but not limited to abuse, neglect, emotional harm, or sexual exploitation by staff
☐ Death
☐Other (Explain):

Staff Involved:
Name:
Name:
Name:
Name:
Name:

Witnesses:
Name:
Name:
Name:
Name:
Name:

Where Incident Occurred:
☐ PRTF
☐ School
☐ Community
☐ Home
☐ Other (Explain):

SECTION IV- NARRATIVE DETAILS
Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants (resident, staff, etc.) and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how, and what was heard and/or observed:

SECTION V- PLAN TO RESOLVE (IMMEDIATE AND LONG TERM)
At the time of the report, is the facility conducting an internal investigation? _____Yes _____No Updated reports should be submitted every 10 business days until the investigation is complete using the **Incident Report Update Form** Describe any corrective action taken to prevent future incidents (including changes to behavior care plan, treatment plan, or medication regimen, etc.): If mistreatment or allegations of mistreatment by staff, actions taken (training, suspension, termination, etc.):

SECTION VI- INDICATE WHCH OF THE FOLLOWING AGENCIES AND INDIVIDUALS HAVE BEEN INFORMED	
Check all that apply and provide: ☐ Parent/Legal Guardian ☐ MS Department of Human Services (DHS) ☐ MS Department of Health (MDH) ☐ Disability Rights Mississippi (DRM) ☐ Medicaid Fraud Control Unit, Attorney General (MFCU) ☐ Center for Medicare/Medicaid Services (CMS) ☐ DMH Office of Incident Management	Name: Date: Name: Date: Name: Date: Name: Date: Name: Date: Name: Date: Name: Date: Name: Date:

SECTION VII – ATTACHMENTS
Are there attachments included with this report? ___Yes _ _No