**Level 1 Critical Incidents results in death or serious injury. They significantly jeopardize clients, public safety or program integrity. Incidents involving clients must be reported to SAMHS, whether or not the incident took place on the program site. When a client’s death is unknown and they die alone this must be reported as a level 1. \*Please do not report incidents that are not client related.\***

*Process: The Director of Crisis Services, Program Operations, and the Executive Director is responsible for formulating a plan which includes contacting DHHS within four (4) hours of the incident becoming known to staff. A faxed, photocopied, or password protected e-mail using this incident report must be submitted to DHHS within twenty four (24) hours.*

**Level 2 Critical Incidents include significant errors or undesirable events that compromise quality of care or client safety.**

*Level 2 Process: The Director of Crisis Services, Program Operations, and the Executive Director is responsible for formulating a plan which includes contacting DHHS within twenty four (24) hours of the incident becoming known to staff. A faxed, photocopied, or password protected e-mail using this incident report must be submitted to DHHS within twenty four (24) hours.*

*The Department of Health and Human Services will review and respond within five (5) working days of receipt.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Agency Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agency Name | | Enter agency name | | | | | | | | | | | Facility Name or Private Residence | | | | | | | | | Enter facility name if different from Agency name | | | | | | |
| Contact Person | | | Enter contact name | | | | | | | | | | | | Office Phone | | | | Enter phone | | | | | | Cell Phone | | Enter phone | |
| Street Address | Enter number and street of agency | | | | | | | | | | | | | | City | | | Enter city | | | | | | | | ZIP | |  |
| **PROGRAM AREA AFFILIATION:** Select appropriate check box for the service | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental Health Services | | | | | | Community | | Residential | | | |  | | | | | | | | | | | | | | | | |
| Substance Abuse Services | | | | | | Opioid Treatment Program | | | | | Residential | | | | | | | | | | Other If Other, enter service | | | | | | | |
| **Level 1 Issue** | | | | Suicide or Homicide | | | Other Unexplained or Unattended Death | | | | | | | | | | | | | | | | Medication Issue (dosing error, theft, loss) | | | | | |
| Self Harm resulting in ER Care for client | | | | | | | | | | Clinical or Medication error resulting in emergency care for client | | | | | | | | | | | | | | |
| Serious crime (arson, assault, hostage) by client with extreme risk of harm to client, staff, or public | | | | | | | | | | | | | Other serious events (fire, flood, MVA, Natural Disaster) | | | | | | | | | | | |
| **Level 2 Issue** | | | | Alleged Physical/sexual abuse of client | | | | | | | Suicide Attempt | | | | | | | | | | | | | Lost or Missing Client | | | | |
| Medication Diversion or refusal against orders | | | | | | | Major physical plant disaster | | | | | | | | | | | | |  | | | | |
| Client Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Client Identifier (initials-DOB-last 4 SSN): Ex. Mk-031567-5868 Enter Client Identifier | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is Client a Class Member? | | | | | | Yes  No | | | | | | | | |  | | | | | | | | | | | | | |
| **INCIDENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Incident | | | | | Enter date | | | | | Time of Incident | | | | | | | | | | Enter time | | | | | | | | |
| Location of Incident | | | | | At Program  In the Community | | | | | | | | | | | | | | | | | | | | | | | |
| **Incident Description: (Include name of staff involved):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type incident description here (1,200 character max) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Agency response to Ensure safety and prevent recurrence (medical, administrative, and follow-up):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type agency response here. (1,200 character max.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NOTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Who was notified (check all that apply):** (Psychiatrist and Medical Provider are required)  Psychiatrist  Medical Provider  Guardian  Family  Police  Therapist  Agency Administrator  DHHS Protective Services  Case Manager/Community Integration Worker  Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DHHS USE ONLY**  **All incidents must be responded to within five (5) working days.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Critical Incident Form Received by: Enter name | | | | | | | | | | | | | | | | Date: Enter date | | | | | | | | | | | | |
| Critical Incident Form Sent to: Enter name | | | | | | | | | | | | | | | | Date of Response: Enter date | | | | | | | | | | | | |
| Method of Communications (check all that apply): | | | | | | | | | Phone Call  Site Visit | | | | | | | | | | | | | | | | | | | |
| Incident Notes and Follow-up Action: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type incident notes and follow-up actions here (1,200 characters max) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |