

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-inflicted Member to Public Public to Member
Other;

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

Table with 3 columns: 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 501-682-8656):
DHS PASSE Ombudsman:
Next of Kin:
Responsible Party (if different from above):
Law Enforcement:
Other:

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Type of Report	<input type="checkbox"/> Initial Written	Date of Incident: _____
	<input type="checkbox"/> Follow-Up	Time of Incident: _____
	<input type="checkbox"/> 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: _____