



MFP Sentinel Event Reporting Form

MFP Field Personnel: using the text boxes provided, complete this form when an MFP participant experiences a critical incident or sentinel event listed. An individual is considered a MFP participants if (s)he or a parent/legal guardian has signed the *MFP Consent for Participation* form.

Date of Report: **Waiver Name:** - Or **Check for MFP CBAY**

Case Mgr/Care or Service Coordinator Name: **Phone:**

Participant First Name: **Participant Last Name:**

Participant Medicaid ID#: **Participant Date of Birth:**

Participant Address: **Participant City:** **Zip:** **County:**

Participant Phone Number: **Other Contact Name:** **Other Phone:**

Provider (if applicable):

Name of the Inpatient Facility Admitted to: (or n/a):

Address of the Inpatient Facility Admitted to: (or n/a):

Date of Incident: **Location of Occurrence:**

Type of Critical Incident/Sentinel Event: (Check only one. Each event requires a separate report.)

- Abuse, Neglect, Exploitation, ***Hospitalization: Admit Date: _____,
- Emergency Room Visit, ***Death, ***Death due to abuse, neglect, or exploitation,
- ***Death due to a breakdown in the 24/7 back-up system, Involvement with Criminal Justice System, Medication Administration Error, Other (specify): _____

*****NOTE: These sentinel events also require the submission of the *MFP Participant Status Change Form (see Appendix Y)*.**

Brief summary of event:

Q1. What did the participant report (or check for NA)?

Q2. What were the adverse outcomes related to the event/injuries (describe in detail)?



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Q3. Who witnessed to the event (list name and contact information)?

Q4. What action was taken by MFP field personnel at time of event (Discovery)?

Q5. MFP Field Personnel Action Plan (Do) - What will field personnel do to prevent this from happening in the future?

Q6. MFP Field Personnel Process improvement (Check) - What MFP processes were instituted to evaluate the effectiveness of the action plan and reduce risk to the participant?

Q7. What are the follow-up time frames (Act/Monitor) for evaluating effectiveness of the processes?

Q8. Who was notified about the event?

	Name	Date	Time
Field Personnel Supervisor:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Physician:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Guardian/Family:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
MFP Project Director:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Agency Name:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other Agency Name:			
Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MFP Field Personnel Name: _____ Phone: _____ Email: _____

MFP Field Personnel Signature: _____

Note: Send this completed form to the appropriate coordinating agency and then to DCH MFP by FTP.