

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@EmpowerArkansas.com
Arkansas Total Care 866-282-6280 Incident@ArkansasTotalCare.com
CareSource PASSE 833-230-2005 Incident.Reporting@CareSourcePASSE.com

Incident Date: Incident Time:
Injured Person's Name:
Address:
Phone Number(s):
Date of Birth: Age:
Gender: Race:
Legal Status: Medicaid#: Member ID#:

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 (501-910-7828 Fax 501-682-8380):
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: _____