PROVIDER INCIDENT REPORT

MI CHOICE WAIVER & CARE MANAGEMENT PROGRAMS

REGION 9 AREA AGENCY ON AGING
A DIVISION OF NEMCSA

This form is to be used whenever a problem is identified with a provider

Complete the appropriate sections and forward to your supervisor for review.

Participant Name: _____ Last 4 Digits of Soc. Security #: _____

Program: ☐ MI Choice Waiver ☐ Care Mgmt. ☐ Caregiver Respite ☐ Other: _____

Provider Agency: _____ Worker Name:_____

Supports Coordinator: _____ Date of Incident:_____

Type of Incident (Select all the apply)

☐ No Notification of Participant Death
☐ Significant delay in initiating service(s)
☐ Inadequate/Incomplete Service(s) :_____
☐ Worker Consistently Late. _____ Number of times with _____
☐ Violation of Code of Ethics:_____
☐ Other:

Action/Resolution (Select all the apply)

☐ Duties clarified with provider and worker
☐ Request to change worker
☐ Changed Provider Agency
☐ SC Staff followed up with participant or their designee
☐ SC staff notified Supervisor
☐ Follow-up Action by Supervisor
☐ SC Staff notified provider. Person Contacted:_____

Comments:

SC Signature: _____ Date: _____

Follow-up done? ☐ Yes ☐ No: _____
Issue resolved? ☐ Yes ☐ No: _____
Describe Resolution:

Supervisor Signature: _____ Date:_____

Director Signature: _____ Date:_____