# INCIDENT REPORT FORM

**Date of Report (Today's Date): _________**

**Beneficiary Name: ___________________________________________________________________**

**Medicaid Number: ___________________________________________________________________**

**Date of Incident: _________ Time of Incident: ______________**

**Location of Incident: _________________________________________________________________**

**Person Reporting Incident (Name and Title): _______________________________________________**

**HMI Office Staff Notified (Name and Title): ______________________________________________**

**HMI Clinician (RN, OT, PT) Notified (Name and Title): ___________________________________**

**Any Other Person(s) Notified (Name and Relationship to Patient): ___________________________**

______________________________________________________________________________________

______________________________________________________________________________________

**Witness(es) to Incident (Name and Relationship to Patient): _________________________________**

______________________________________________________________________________________

______________________________________________________________________________________

**Narration/Summary of Incident: (use additional pages if necessary)**

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Actions Taken/Comments/Follow-up: (use additional pages if necessary)**

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

## FAX TO 202-829-9192 WITHIN 24 HOURS OF INCIDENT

Health Management, Inc. (HMI) Home Health Agency * 1707 L St, NW #900, Washington, DC 20036 * 202-829-1111 (phone)