

**Critical Incident Report Form**  
**Wyoming Care Management Entity**

send to [WYQuality@magellanhealth.com](mailto:WYQuality@magellanhealth.com) and [WYClinical@magellanhealth.com](mailto:WYClinical@magellanhealth.com)

If suspected abuse, neglect, abandonment or exploitation, **immediate action is required**  
contact local law enforcement or the Local Office of the  
Department of Family Services (DFS) to make verbal a mandatory report and  
also send a copy of this report to the Wyoming Department of Health and Division of Healthcare Financing  
via email to [Lisa.Brockman@wyo.gov](mailto:Lisa.Brockman@wyo.gov), within 24 hours

**Date of Incident:**

**Where Incident Occurred:**

**Date of Reporting:**

**Provider/Facility Reporting:**

**Member Name:**

**Medicaid #:**

**Type of Incident:**

- Suspected abuse, including intimidation
- Suspected sexual abuse
- Suspected neglect
- Suspected self-neglect
- Suspected self-abuse
- Suspected abandonment
- Suspected exploitation
- Police involvement
- Injuries caused by restraints
- Injury to the member
- Crime committed by a member
- Elopement
- Medication errors
- Use of restraints
- Suicide threat/attempt
- Homicide threat/attempt
- Self-harm, requiring medical intervention
- Death

**Description of Event** (including trigger, de-escalation attempts):

**Result of Incident** (including injuries, property damage, legal charges, behavioral consequences, modification to treatment plan, modification to crisis/safety plan):

**Actions Taken** (including crisis meeting or CFT held within 24 hours of incident, post incident medical interventions, member/staff debriefing, additional support or services recommended):

**Notification:**

	<b>Who</b>	<b>Date</b>	<b>Time</b>	<b>Method</b>
1.				
2.				
3.				
4.				
5.				

**Did this incident result in a mandatory report?**

- Yes**
- No**

**Did this incident result in an out of home placement?**

- Yes**
- No**

*\*Requires an Out of home placement form within 24hrs and emailed to [WYClincial@magellanhealth.com](mailto:WYClincial@magellanhealth.com)*

**Critical Incident Form completed by:**

**Address:**

**Phone:**