MISSISSIPPI DIVISION OF MEDICAID

ELDERLY & DISABLED WAIVER REPORTABLE INCIDENTS FORM

CASE MANAGEMENT AGENCY: _____

PROJECT SITE/COUNTY: _____

CASE MANAGER: _____

BENEFICIARY'S NAME: _____

MEDICAID NUMBER: - -

PROVIDER NAME: _____

PROVIDER NUMBER: _____

TYPE OF INCIDENT:

ABUSE:	☐	EVV MISUSE:	☐
NEGLECT:	☐	FRAUD:	☐
EXPLOITATION:	☐	DEATH:	☐

OTHER: _____

DATE OF INCIDENT: / /

DATE REPORTED (DHS): / /

DATE REPORTED (DOM): / /

APS/DHS REPORT #: _____

DATE RESOLVED: / /

Please describe in detail the nature of the incident as well as the resolution, including the name of the Agency and PCA (if applicable). Attach any supporting documents.