

Please fax to HNE Provider
Relations at 413.233.2808



Health New England Be Healthy – MassHealth Daily Adverse Incident Report

Notifications: DMH ___ DCF ___ DYS ___ DPPC ___ DDS ___ Other ___

Client: _____ Medicaid RID #: _____

M ___ F ___ DOB: _____ Age: _____

Facility: _____ Unit: _____ City: _____

24-hour facility: _____ Non 24-hour facility: _____

Date and Time of Incident: _____

Date and Time of Discovery: _____

Type of Incident: _____

Describe Incident. If AWA, please include search, notification and commitment status:

Describe Immediate Response to the Incident:

Restraints Used? None: ___ Mechanical: ___ Chemical: ___ Physical: ___ **Time in Restraints:** _____

Please Check if Recommended: Internal Investigation _____ Policy and Procedure Review _____

Staff training _____ Disciplinary action to staff _____

Please check if additional information is attached. ___

Person Reporting: _____ **Telephone #:** _____

Title: _____

Signature: _____ **Date:** _____