Critical incident report form

Please complete and submit this form to UnitedHealthcare Community Plan when you:

- Report abuse, neglect or exploitation of a UnitedHealthcare Community Plan member to the Texas Department of Family and Protective Services (DFPS)
- Become aware of a critical incident, including abuse, neglect or exploitation, related to a UnitedHealthcare Community Plan member

This notification should **not** take the place of reporting to DFPS at 800-252-5400 or **TXAbuseHotline.org**. For more information, please view our **Critical Incident Reporting: Including Abuse, Neglect and Exploitation training.**

Submit this form by:
Email: critical_incidents@uhc.com | **Fax:** 855-371-7638

If you need assistance completing the form, please contact your provider advocate or email us at **critical_incidents@uhc.com.**

Member's name:

Member's UnitedHealthcare Community Plan ID number:

Member's address:

City:	State:	ZIP code:

Member's date of birth:

Member's UnitedHealthcare Community Plan benefit plan (choose one):

- ☐ Children's Health Insurance Program (CHIP)
- ☐ STAR
- ☐ STAR+PLUS
- ☐ STAR Kids
- ☐ Unknown
- ☐ UnitedHealthcare Connected® (Medicare-Medicaid Plan)
- ☐ UnitedHealthcare Dual Complete® Special Needs Plan

Is the member on a waiver (choose one)? ☐ Yes ☐ No ☐ Unknown

Service area where the member lives (choose one):

- ☐ Bexar
- ☐ Dallas
- ☐ Jefferson
- ☐ Harris
- ☐ Hidalgo
- ☐ Medicaid Rural Service Area Central
- ☐ Medicaid Rural Service Area Northeast
- ☐ Nueces
- ☐ Tarrant
- ☐ Travis
- ☐ Unknown

UnitedHealthcare® Community Plan

Choose the type of incident (choose one):

- ☐ Abuse
- ☐ Neglect
- ☐ Exploitation
- ☐ Unauthorized use of restraint, seclusion or restrictive interventions
- ☐ Serious injury that resulted in medical intervention or hospitalization
- ☐ Criminal victimization
- ☐ Death
- ☐ Other (please describe)

Describe the incident (attach another sheet if necessary).

Describe any actions taken as a result of incident.

Who caused the incident (if applicable)?

Name of the person who first became aware of the incident and their relationship to the member:

Where did the incident occur (choose one)?

- ☐ Family home
- ☐ Group home or assisted living facility
- ☐ Medical facility
- ☐ Nursing facility
- ☐ School
- ☐ Place of employment
- ☐ Other (please describe):

Incident date:	**Incident time:**

Was the incident reported to local emergency authorities? ☐ Yes. When? ☐ No

Was the incident reported to the Texas Department of Family and Protective Services?
(Required for any abuse, neglect or exploitation incidents)

☐ Yes. When?	DFPS incident number:
☐ No	

Your name:	**Your relationship to the member:**

Your or your agency's tax identification number:

Your or your agency's email address:

Which best describes you or your agency?

- ☐ Long-term services and supports (LTSS) (please describe):
- ☐ Primary care provider
- ☐ Specialty provider (please describe):
- ☐ Other (please describe)

Date you completed this form:

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Questions?

Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal.** For additional contact information, visit our **Contact us** page.

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