Confidential Critical Incident Reporting Instructions & Reminders

Confidentiality notice: Do **not** copy or distribute a completed Confidential Critical Incident Reporting Form.

Reporting guidelines: Please complete and submit the Confidential Critical Incident Reporting Form, including additional supporting documents, to Molina Healthcare of Nebraska, Inc. (Molina) when you:

- Report abuse, neglect or exploitation of a Molina member to the Nebraska Department of Health and Human Services (DHHS).
- Become aware of a critical incident involving a Molina member, including abuse, neglect or exploitation.

Reporting requirements:

- All critical incidents must be reported **immediately** to Nebraska DHHS and, when applicable, to law enforcement, *before* being submitted to Molina.
- This form must be completed by the reporting party and submitted as instructed.
- The submission of this form does **not** replace reporting to Nebraska DHHS. To report abuse, neglect or exploitation of a Medicaid member, call the DHHS Children and Family Services Abuse and Neglect Hotline at (800) 652-1999. This toll-free hotline is available 24 hours a day, 7 days a week.

Care and documentation reminders:

Before submitting this form, please ensure:

- All necessary steps have been taken to support and treat anyone injured and to prevent injury to others.
- Medical records are factual, complete, and up to date.
- All follow-up actions have been initiated and documented as appropriate.

For assistance, please email the Healthcare Services team at NE_CM@MolinaHealthcare.com.

☑ **Submit the Confidential Critical Incident Reporting Form by email:**
NE_CM@MolinaHealthcare.com

Confidential Critical Incident Reporting Form

A. Member Details

First Name:	**Last Name:**	**Molina ID:**
Date of birth:	**Age:**	**Telephone:**

B. Reporting Party Details

First Name:	**Last Name**:	
Title:	**Date Incident Identified:**	
Agencies Notified: *(Select all that apply)*	☐ Department of Health and Human Services (DHHS)	**Date Reported:**
	☐ Other (specify):	**Date Reported:**

C. Incident Information

Date of Incident:		**Time of Incident:**		
Incident Address: *(If known)*	Street:		City:	
	State:		ZIP:	
Place of Incident: *(If known)*	☐ Own home	☐ Home of another	☐ Supportive living	☐ Hospital
	☐ Nursing facility		☐ Other (specify):	

D. Reportable Incidents *(select all that apply)*

1. Death & Life-Threatening Events

☐ Homicide	☐ Homicide attempt	☐ Suicide	☐ Suicide attempt
☐ Unexpected death	☐ Other (specify):		

2. Abuse, Neglect, and Exploitation

☐ Allegations of abandonment	☐ Allegations of physical abuse, including assault and battery
☐ Allegations of exploitation (e.g., financial, material, or other non-sexual)	☐ Allegations of psychological/emotional abuse (e.g., coercion, humiliation, insults, intimidation, isolation, verbal threats)
☐ Allegations of neglect	☐ Allegations of sexual abuse, including sexual exploitation and sexual harassment

3. Serious Injury and Medical/Psychiatric Events

☐ Accidental injury requiring significant medical intervention	☐ Self-inflicted injury or wound requiring medical intervention
☐ Adverse drug reaction requiring medical intervention	☐ Significant psychiatric event or behavioral health crisis requiring medical intervention

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☐ Medication error requiring medical intervention		☐ Unexpected serious illness/disease or other emergency medical treatment	
4. Restraints and Seclusion			
☐ Unauthorized use of restraints	☐ Unauthorized seclusion	☐ Restraint injury	☐ Seclusion injury
5. Criminal or Law Enforcement Involvement			
☐ Criminal act of any kind involving a member as alleged perpetrator, victim, witness or other direct involvement (e.g., setting fires and damaging property)		☐ Law enforcement involvement with a provider or caregiver related to member care or safety	
☐ Elopement or missing person		☐ Other law enforcement involvement (please describe):	
E. Brief Description of Incident(s), Actions Taken, and Outcomes *(attach a page as needed)*			
F. Reporting Party Signature			
Signature:		**Today's date:**	

Thank you for completing this form. Please email it to NE_CM@MolinaHealthcare.com.