INCIDENTS, CLAIMS AND MEDICAL RECORDS REPORTING

You are required to report all incidents to our claim's administrators, RYZE Claims Solutions LLC dba Certus Claims Administration, by completing the attached Incident Form, and submitting it by email, fax or regular.

Reporting Email: VCMclaims@certusclaims.com
Fax: 805-987-8806
Mail: Certus Claims Administration, P.O. Box 1030, Camarillo, CA 93011-1030
Phone: 805-987-8803
Website: www.certusclaims.com

Reporting of all incidents (ie: falls, abuse, contusions, elopements, etc.) is necessary to capture all details in a timely manner.

Immediate reporting for any of the following occurrences:

- Claims or demand for money
- Lawsuits
- Letters from attorneys
- Subpoenas
- Record requests
- Letter from any federal and/or state agencies in relation to fines and penalties, if you have Administrative Procedures Protection insurance cover included in your policy.

Please submit all useful information with the incident report including but not limited to:

- Photographs
- Witness statements
- Clear descriptions of location
- Specific injuries sustained
- Retain any video footage available

****Please note that reporting an incident does not mean that your premiums would increase or your policy cancelled.*

CLAIMS INCIDENT REPORTING FORM

Today's date_____

Facility Full Name:	**Facility Contact:**	**Phone No. (including area code)**
Facility Street Address:	**Incident Involved:** (circle) **Resident Visitor Employee**	**Date of Incident:**
City: **State: Zip:**	**If Visitor / Employee :** (reason for being in the location)	**Time of Incident:** _____**am** _____**pm**
If Employee, Department:	**Job Title:**	**Length of time in this position:**

RESIDENT/VISITIOR/EMPLOYEE INFORMATION:

Name:	**Gender: □ Male □ Female**	**Age:**
Address:	**Full Social Security Number:**	**Date of Birth:**
City: State: Zip:	**Payer Source: (check one)** **□ Private Pay □ Medicare □ Medicaid**	**Admit Date:**_____ **Discharge Date:** _____
Admitting Diagnosis:	**Assistive devices in use?** **□ Walker □ Cane □ Wheelchair**	**Resident has a history of falls?** **□ Yes □ No**
Resident Condition before incident: **□ Confused □ Normal □ Disoriented □ Sedated** **Shift (circle one):** **Day:(**6a-6p) **Evening:**(6p - 12a) **Night:** (12 a-6 a)	**Physical or Chemical Restraint in use? □ Yes □ No** **Type: □Physical □ Chemical □ Full Bedrail □ 1/2 siderail** **□ other**_____ **If chemical or sedated with hypnotic or behavioral drug:** **Name of Drug:**_____ **Dose**_____**Time:** _____	
Exact Location of Incident / Accident: □ResidentRm# _____ **□ Hallway □ Bathroom □ Dining Rm □ Patio □ Shower** **□ Driveway □ Activity Rm □ Living Room □Other**_____	**Are Doctor's orders in place for restraints? □ Yes □ No** **reason:**_____ **Order renewed & re-evaluated every six months? □ Yes □ No**	
Vital Signs: Temp._____**Pulse**_____ **Resp.** _____ **B/P**_____**/**_____**□ Loss of consciousness**	**Was Equip. involved? □ Yes □ No** **Describe:**	**Recurrent incident in 6 months?** **□ Yes □ No**

Circumstances of Incident: (describe)

_____

_____

Type of Incident: □ Witnessed Fall □ Found on floor □ Transferring **□ Behavioral aggressive □ Abuse Neglect or Exploitation** **□ Equipment Malfunction □ Elopement □ Medication Error □Theft** **□ Vandalism □ Unknown**	**Outcome: □ No Injury □ Surgery □ ER** **□ Admitted to Hospital □ D/C to Higher Level ofCare** **□ Death, if yes, was case referred to ME: □ Yes □No**
Injury : □ Yes □ No Body Part(s) Injured:_____ **□Cut/laceration/Skin Tear/Abrasion □ Bruise/ Bleed □Swelling □Burn** **□ Fracture/Dislocation □ Sprain / Strain □ Medication Related**	**Reported to State: □ Yes □ No** **Police called: □ Yes □No** **Reported Abuse: □ Yes □ No**
Witnessed or Responded to by: **Name:**_____**SS or License #:**_____ **Name:**_____**SS or License#:**_____	**Treatment: □ None NEEDED □ 1st aid at Facility** **□ ER □ Admitted Hospital □ Dr. office** **□ other**_____
Legal Representative Called & Notified: (name and relationship to resident) **Name:**_____**Time:** _____am/pm	**Incident Report completed by:**
Physician Called & Notified: **Name:**_____**Time:**_____ am/pm	**Reviewed by Administrator:** **Sign:**_____

*The PHI (personal health information) contained in this FAX/Email is **HIGHLY CONFIDENTIAL**. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this resident. Any other use is a violation of federal law (HIPAA) and will be reported as such. This material is to be considered part of the Peer Review process and for internal Risk Management purposes only. It is also considered as part of work by product in anticipation of litigation and as such is considered as part of and protected by attorney client privilege.*

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