MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

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Behavioral Health and Developmental Disabilities Division ♦ Children's Mental Health Bureau

♦ 111 N. Sanders Rm 307 ♦ PO Box 4210 ♦ Helena, MT 59604-4210 ♦ Voice: 406-444-4545 ♦ Fax: 406-444-5913

REPORT OF SERIOUS OCCURRENCE

Instructions:

Requirements for documenting reports of serious occurrences are set out in 42 CFR § 483.374.

Psychiatric Residential Treatment Facilities (PRTF) as defined in 42 CFR § 483.352 MUST report any serious occurrence involving a resident to the Children's Mental Health Bureau (CMHB) of Montana Medicaid by no later than the close of business on the next business day after a serious occurrence.

This form must be completed in its entirety and sent to AlWilson@mt.gov via the State of Montana File Transfer Service (ePass). If you do not have an ePass account, one can be created here: https://oktaloginmt.com. Forms may also be faxed to CMHB at (406)444-5913. **Please note sending protected health information via unsecure email is a violation of HIPAA.**

Pursuant to 42 CFR § 483.374(c), the DEATH of a resident MUST be reported to a Centers for Medicare and Medicaid Services (CMS) regional office by no later than 6:00 P.M. Central Time on the next business day after the resident's death.

Facility Information:

Facility Name and Address: _____

_____

Name and Job Title of Person Completing Report: _____

Phone Number: _____

Email Address: _____

Who to Contact – Name, Phone Number, and Email Address (If different from person completing report): _____

_____

Resident Information:

Name: _____

Date of Admission: _____

Name of Guardian and Relationship to Resident: _____

Guardian Address: _____

Guardian Phone Number: _____

Has the guardian been notified of the serious occurrence? ☐ Yes ☐ No

If Yes is indicated, name of person who notified guardian: _____

Date/Time of guardian notification: _____

If No is indicated, please state why the guardian has not been notified and the facility's plan to issue notification: _____

_____

_____

Details of Occurrence:

Was Child Protective Service (CPS) notified of the serious occurrence? ☐ Yes ☐ No

Type of Serious Occurrence: ☐ Death ☐ Suicide Attempt ☐ Serious Injury

Date and Time of Serious Occurrence:_____

Location of Serious Occurrence: _____

If Death is indicated, Date and Time of Report to CMS: _____

Is the report to CMS documented in the resident's record as required? ☐ Yes ☐ No

Did the serious occurrence occur during the use of either restraint or seclusion? ☐ Yes ☐ No

Was medication used during the course of the serious occurrence? ☐ Yes ☐ No

If Yes is indicated, please list the name of the medication, the dosage used, and the resident's response:

_____

_____

Please provide a detailed description of the serious occurrence. Include triggering events, details of the serious occurrence, and follow up actions taken after the event. Include any follow up done with the resident and/or staff involved:

_____

_____

_____

_____

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_____

Number of additional sheets attached (if none, please indicate none): _____

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