| **Individual’s Name** *[Individual on whose behalf the Sentinel Event Report is being completed.]* |
| --- |
| **Last Name:**       | **First Name:**       | **Middle Initial:**       |
| **Date of Sentinel Event:** Click or tap to enter a date. | **Report Date:** Click or tap to enter a date. |
| **I - BACKGROUND** |
| 1. **Type of Sentinel Event [check all that apply]:**
 |
| [ ] Unanticipated death is a sudden or accidental death.*Note: Does not include homicide or suicide; and, is not related to the natural course of an illness or underlying condition*.  | [ ] Permanent loss of function, resulting from such causes including but not limited to:* medication error;
* unauthorized departure or abduction from a facility providing care; or,
* delay or failure to provide requested and/or medically necessary services due to waitlists, availability, insurance coverage or resource limitations.
 |
| [ ] Homicide victim[ ] Homicide perpetrator | [ ] Suicide |
| [ ] Serious physical injury, or risk thereof to or by a client (jeopardizing a person’s health). | [ ] Serious psychological injury that jeopardizes the person’s health that is associated with the planning and delivery of care. |
| [ ] Victim of rape or any other sexual assault[ ] Perpetrator of rape or any other sexual assault | [ ] Injury due to physical or mechanical restraints. |
| [ ] Suicide attempt that has explicit or implicit evidence that the individual intended to die and medical intervention was needed. | [ ] High profile event such as media coverage, police involvement, etc. |
| 1. **Location of Sentinel Event:**

[ ] Primary Residence [ ] Other Residence [ ] Business [ ] Other:  |
| Street Address:       | City/Town:       |
| 1. **DHHS Agencies/Programs Serving the Client:**
 |
| [ ] Adult Protective Services  | [ ] Mental Health Services | [ ] Choices for Independence Waiver |
| [ ] Child Protective Services | [ ] Juvenile Probation and Parole | [ ] Sununu Youth Services Center |
| [ ] Drug and Alcohol Services | [ ] Elderly and Adult Services | [ ] Family Assistance |
| [ ] New Hampshire Hospital | [ ] Housing Supports | [ ] Employment Supports |
| [ ] Glencliff Home  | [ ] Transitional Housing | [ ] Laconia BDS DRF |
| [ ] Child Development and Head Start Collaboration | [ ] Developmental Services | [ ] Other (specify):       |
| 1. **Individual’s DHHS Case Status [check all that apply]:**
 |
| [ ] Currently receiving DHHS-funded services.[ ] Has received DHHS-funded services within the preceding 30 days. |
| [ ] Has received services through Emergency Services provided by a Community Mental Health Center.[ ] Has received psychiatric hospitalization within the past year of the suicide death. |
| [ ] Is receiving services from Child or Adult Protective Services.[ ] Other:       |
| 1. **Reported by [check applicable box and complete the name or location if applicable]:**
 |
| [ ] Adult Protective Services | District Office:       |
| [ ] Mental Health Services | Community Mental Health Center:       |
| [ ] DCYF – Child Protection | District Office:       |
| [ ] DCYF – Juvenile Justice | District Office:       |
| [ ] Choices for Independence (CFI) | Case Management Agency:       |
| [ ] Designated Receiving Facility (DRF) | Name:       |
| [ ] Developmental Services | Area Agency:       |
| [ ] Drug and Alcohol Service | Agency:       |
| [ ] Bureau of Housing Supports | Agency:       |
| [ ] Division of Economic Housing Stability (DEHS) Other | Bureau: Click or tap here to enter text. |
| [ ] Managed Care Organization (MCO): | [ ] AmeriHealth Caritas NH [ ] NH Healthy Families [ ] Well Sense |
| [ ] New Hampshire Hospital (NHH) |  |
| [ ] Harbor Homes |  |
| [ ] Glencliff Home for the Elderly |  |
| [ ] Sununu Youth Services Center |  |
| [ ] Laconia BDS DRF |  |
| [ ] Other (specify):       |
| 1. **Person Completing the Sentinel Event Reporting Form:**
 |
| Last Name:       | First Name:       |
| Work Phone:       | Mobile Phone:       |
| Work Email:       | Relationship to Individual:       |
| 1. **Person to Contact for Additional Information:**
 |
| Last Name:       | First Name:       |
| Work Phone:       | Mobile Phone:       |
| Work Email:       | Relationship to Individual:       |
| **II – INDIVIDUAL’S DETAILS**[Individual on whose behalf the Sentinel Event Report is being completed.] |
| 1. **Demographics:**

[ ] Male [ ] Female [ ] Other (specify):       | Date of Birth: Click or tap to enter a date. | Age:       |
| Street Address:       | City/Town:       | Zip:       |
| 1. **NH Medicaid Status:**

Is the individual receiving Medicaid benefits? [ ] No [ ] Yes with Member ID#:        |
| Date MCO Notified: Click or tap to enter a date. | [ ] AmeriHealth Caritas [ ] NH Healthy Families [ ] Well Sense |
| 1. **Legal Factors [Identify any legal factors(s) the individual may have.]:**
 |
| ***Child Protection [check all that apply]:*** | ***Community Care [check all that apply]:*** |
| [ ] Abused[ ] Neglected[ ] Guardianship[ ] Co-Guardianship[ ] Out-of-home care / physical custody[ ] Foster family care[ ] Relative/kinship care[ ] Residential/congregate living[ ] Individual Service Option (ISO) | [ ] Authorized Representative (Individual has identified someone to act on his/her behalf for a specific purpose)[ ] Conditional Discharge (Adult or child)[ ] Court Involved Adult Protection Open Case[ ] Durable Power of Attorney (DPOA)[ ] DPOA for Health Care[ ] Guardian of Estate[ ] Guardian of Person |
| ***Juvenile Justice Services [check all that apply]:***[ ] Child in Need of Services (CHINS)[ ] Delinquent[ ] Detained[ ] Committed to Sununu Youth Services Center[ ] Furlough[ ] Medical furlough[ ] Administrative furlough[ ] Administrative release[ ] Detained pending revocation[ ] Parole | ***Psychiatric hospitalization: New Hampshire Hospital, Designated Receiving Facility (DRF), or a behavioral/psychiatric unit in a general hospital [check all that apply]:***[ ] Involuntary Emergency Admission (IEA) up to 10 days[ ] Involuntary commitment by probate (admission beyond 10 days)[ ] Revocation of Conditional Discharge (CD)[ ] Voluntary psychiatric admission [ ] **Other (specify):**       |
| 1. **All Current Diagnosis(es):**
 |
| **Psychiatric** | **Medical** |
|       |       |
|       |       |
|       |       |
|       |       |
| 1. **Individual’s Services [List all services the individual is or was receiving if case was recently closed]:**
 |
| 1.
 | 1.
 |
| 1.
 | 1.
 |
| 1.
 | 1.
 |
| 1.
 | 1.
 |
| **III - SENTINEL EVENT DETAILS** |
| 1. **Description of Event Details:**
 |
| 1. What happened?
 |
| 1. If known, what were the precipitating factors?
 |
| 1. When did it happen?
 |
| 1. Where did it happen?
 |
| 1. How did it happen?
 |
| 1. Were there any witness(es)? [ ] Unknown [ ] No [ ] Yes (answer 13.g)
 |
| 1. Provide any relevant details about witness(es) *(name, contact information, etc.):*
 |
| 1. Other relevant information:
 |
| 1. **Use of Restraints:**
 |
| [ ] None Used [ ] Physical [ ] Mechanical [ ] ChemicalIf known, minutes in restraints:       |
| 1. **Individual’s Housing:**

Was the individual in a 24-hour residential facility, community residence, shelter, or institution within 30 days preceding the sentinel event? [ ] No [ ] Unknown [ ] Homeless [ ] Yes, then complete the next sections |
| Facility Name:       | Facility Location:       |
| **Facility Type [check the applicable box]:** |
| [ ] Adult family care | [ ] Prison/jail |
| [ ] Acute Psychiatric Residential Treatment Program (APRTP) | [ ] Residential care/assisted living |
| [ ] Community residence-certified (group home, shelter) | [ ] Respite *(type of facility):* |
| [ ] Group home | [ ] Residential treatment facility |
| [ ] Psychiatric hospital or Designated Receiving Facility (DRF) | [ ] Shelter |
| [ ] Medical/general hospital | [ ] Substance use disorder treatment facility |
| [ ] Mid-level care facility | [ ] Sununu Youth Services Center |
| [ ] Skilled nursing facility |  |
| [ ] Other (describe):       |
| **IV - INITIAL NOTIFICATION** |
| DHHS Division / Bureau:        |
| DHHS Director / Administrator:       |
| Date Notified: Click or tap to enter a date.Method of Notification: [ ] Telephone [ ] Voice Mail (VM) [ ] Other (specify):       |
| **V – ADDITIONAL INFORMATION** |
| * Additional information regarding the sentinel event shall be reported as it becomes available, and upon the Department’s request.
* As they are learned, additional details may include a change in status of the situation, links to relevant newspaper articles, etc.
	+ To submit Additional Information for a previously reported Sentinel Event, upload a separate document to the eStudio application.
	+ Use the following naming convention so that the Additional Information document remains part of the report history. For example:

*PHI\_SE\_FIRSTNAME\_LASTINITIAL\_document description\_YYYY-MM\_DD* |