

To be filled out by OCFS BWM Only:
REPORT NUMBER:

Complete the following:

1. Provide a clear and objective description of the event. *(attach additional sheets if necessary).*
2. List actions taken as a result of the incident that impact the child's ability to continue receiving B2H Medicaid Services *(either in this setting or by the involved B2H Medicaid Waiver Service Provider(s)).*
3. Is there a known history of similar incidents involving this child? No Yes **If Yes**, please explain.
4. List the follow-up steps to be taken.

STATUS RECOMMENDATION:
 At this time, the Lead Agency Representative recommends the following:
 Continue Inquiry
 Close Inquiry
 Reason for Recommendation:

LEAD AGENCY REPRESENTATIVE NAME:	LEAD AGENCY REPRESENTATIVE SIGNATURE: X	DATE:
LEAD AGENCY NAME:		PHONE #:
LEAD AGENCY ADDRESS:	CITY:	STATE: ZIP CODE #: