

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**SERIOUS REPORTABLE INCIDENT RESPONSE FORM**  
BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES  
MEDICAID WAIVER PROGRAM

To be filled out by Office of Children and Family Services (OCFS) Bureau of Waiver Management (BWM) Only:  
**REPORT NUMBER:**  
\_\_\_\_\_

CHILD'S NAME (LAST, FIRST, MI.):			OCFS-8021 REPORT DATE:
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	INCIDENT DATE:	MEDICAID CIN #:

**B2H WAIVER TYPE:** *(Check one only)*

B2H Serious Emotional Disturbance (SED) Waiver

B2H Developmental Disabilities (DD) Waiver

B2H Medically Fragile (MedF) Waiver

**RESPONSE TYPE:** *(Check one only)*

PRELIMINARY INTERIM RESPONSE

FINAL RESPONSE

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

**RESPONSE REGARDING:** *(Check one only)*

Serious Reportable Incident Form, OCFS-8021, received on: \_\_\_ / \_\_\_ / \_\_\_.

**OR**

Serious Reportable Incident Status/Progress Report, OCFS-8022, received on: \_\_\_ / \_\_\_ / \_\_\_.

**DECISION:** *(Check one only)*

The incident is considered **OPEN**.  
OCFS-8022 must be submitted by \_\_\_ / \_\_\_ / \_\_\_ .  
Submit further information regarding: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

No further reporting to OCFS is required.

REASON FOR DECISION:

\_\_\_\_\_

\_\_\_\_\_

OCFS CONTACT'S NAME:	OCFS CONTACT'S SIGNATURE: <b>X</b>	DATE:
OCFS CONTACT'S TITLE:	PHONE #:	
OCFS CONTACT'S ADDRESS:	CITY:	STATE: