

# Show Me Healthy Kids

MANAGED BY HOME STATE HEALTH

# Member Incident Form

Notification of Hospitalization, Elopement,  
Overnight Home Visit, or Detention

Member's Current Level of Care	Treatment Foster Care (TFC)
	Residential Treatment Center (RTC)
Member Name	
Member DCN	
Member DOB	
Reporting Provider Name	
Date of Event(s) <i>(Hospital admit date, or 1st date of member elopement, or Overnight Therapeutic Home Visit or detention)</i>	
Agency and/or Provider Contact <i>for additional questions (Name, Phone, Email)</i>	
Expected Discharge Date, If applicable	
Date of Member's Return, If applicable	
Facility name in which member has been hospitalized, if applicable	
Barriers to members return	<b>Yes</b> <b>No</b>
Additional details / notes:	

Please return form via fax within 1 business day to 1-833-966-0769