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) (*Hospital admit date, or 1st date of member elopement, or Overnight Therapeutic Home Visit or detention)*	
Agency and/or Provider Contact *for additional questions (Name, Phone, Email)*	
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	**Yes** ☐ **No** ☐
Additional details / notes:	

Please return form via email within 1 business day to
HSHPRequests@homestatehealth.com