DPHHS-AMDD-129
(Rev 9/10)

STATE OF MONTANA
Department of Public Health and Human Services

SERIOUS OCCURRENCE REPORT

PROGRAM _____ **DATE:** _____
RECIPIENT _____ **MEDICAID ID #** _____
REPORTER: _____

PROVIDER

INCIDENT (what occurred):

EFFECT (What resulted from the condition):

CAUSE (Why did it occur):

ACTION: (Address cause):

Resolved: Yes ☐ **No** ☐ **(Forward all copies to Community Program Officer for completion.)**

DPHHS

Comments: _____

☐ **Reviewed** ☐ **Memo** ☐ **Training** ☐ **Case Conference** ☐ **Sanction**

Community Program Officer _____ **Date:** _____

Distribution: Agency; Community Program Officer; Agency suspense file