TEXAS Health and Human Services

Form 3613
March 2023

Fax Cover Sheet

For Home and Community Support Services Agency
(Home Health, Personal Assistance Services and Hospice) Provider Use Only

Date: _____

To: **Complaint and Incident Intake**

Email to: **ciiprovider@hhs.texas.gov**

Area Code and Fax No.: **877-438-5827 (if 15 total pages or fewer)**

Office Area Code and Phone No.: _____

Regarding Intake ID No.: _____

No. of Pages, including cover: _____

From:

Name of Agency Representative: _____

Title of Agency Representative: _____

Reporter Email Address: _____

Office Area Code and Phone No.: _____

Provider Investigation Report Information	
Agency Name	License No.
Street Address	
City, State, ZIP Code	Area Code and Phone No.
Reporter Email Address	◯ Parent ◯ Branch or Alternate Delivery Site

Confidential Document

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TEXAS Health and Human Services

Home and Community Support Services Agency

Provider Investigation Report

(Home Health, Hospice and Personal Assistance Services Provider Use Only)

Form 3613
March 2023

Fax this report to *(if 15 total pages or fewer)*: 877-438-5827

Email this report to: ciiprovider@hhs.texas.gov

Mail this report to: Texas Health and Human Services Commission, Regulatory Services, Complaint and Incident Intake, Mail Code E-249, P.O. Box 149030, Austin, TX 78714-9030

Note to reporter: Fax, Mail or Email One Time Only

Attach all documents and pertinent information that might be needed for HHSC to complete the review of your investigation. Your HHSC Regional Office may also contact you to request additional information to complete the review.

HHSC Intake ID No.	Date Reported to HHSC 800-458-9858	Time ___ : ___ ◯ a.m. ◯ p.m.	DFPS Call ID No.

Provider Type HCSSA	License No.	Area Code and Phone No.
Name	Reporter Email Address	

Street Address	City	ZIP Code	County

Incident Category	Who made the allegation?	When?
Incident Date	Time ___ : ___ ◯ a.m. ◯ p.m.	Location

Description of the Allegation

Individual or Patient Name	Sex	Social Security No.	Date of Birth

Individual or Patient Street Address

☐ Check here if individual or patient address below is a residential facility or in-patient hospice.

City	State	ZIP Code	Area Code and Phone No.

Payment Source	Functional Assistance Needs Status

If applicable, describe any special supervision required.	Age at the time of the allegation

Services Provided *(type, No. of hours)*

Independently ambulatory:	◯ Yes	◯ No	Interviewable:	◯ Yes	◯ No	Capacity to make informed decisions:	◯ Yes	◯ No
Known history of:								
Combativeness:	◯ Yes	◯ No	Similar allegations:	◯ Yes	◯ No	Wandering	◯ Yes	◯ No
Sexual Misconduct:	◯ Yes	◯ No	Verbal aggression:	◯ Yes	◯ No	Physical aggression	◯ Yes	◯ No

Diagnosis and Pertinent History

HHSC Intake ID No.	Agency Name	License or Certificate No.

Alleged Perpetrator(s) (AP)

Attach documentation of any criminal history check searches, nurse aide registry searches and employee misconduct registry searches conducted to verify the employability of the alleged perpetrator. Do not send printed copies of actual criminal history reports obtained from the Department of Public Safety (DPS) secure site.

Staff Name *(includes family if employed by, volunteering with or contracted to the agency)*	**Date of Birth**	**Social Security No.**	**License or Certificate No.**

How was the alleged perpetrator (AP) identified? ◯ By Name ◯ By Description ◯ Other _____

The alleged perpetrator (AP): ◯ Denied ◯ Confirmed

History of similar allegations? ◯ Yes ◯ No

Did investigation reveal the presence of a witness? ◯ Yes ◯ No

Statement attached (signed and notarized if possible)? ◯ Yes ◯ No

Witness(es) Name	Relationship
Address	**Area Code and Phone No.**

Injury or adverse effect? ◯ Yes ◯ No	Assessment Date	Time ___ : ___ ◯ a.m. ◯ p.m.

Description of Injury and Assessment

Treatment provided? ◯ Yes ◯ No	Treatment or Transfer Date	Time ___ : ___ ◯ a.m. ◯ p.m.

Treatment Location *(name and complete address)*	**In-House?**
	◯ Yes ◯ No
	◯ Yes ◯ No
	◯ Yes ◯ No

Agency Immediate Response

Investigation Summary (attach additional sheets as necessary)

Investigation Findings

Agency Action Post-Investigation

Note: HHSC does not accept this report as complete until the reporter's signature, printed name, title and date have been entered below.

Printed Name	**Signature**	**Title**	**Date**