Assisted Living Facility Monthly Liability Claim Information

Refer to section 429.23(5), Florida Statutes. This form is required to be completed and submitted monthly to the Agency for Health Care Administration. Please send this report by the 10th of each month for claims filed the preceding calendar month.

Send the completed form to:

Agency for Health Care Administration
Facility Data Analysis Unit
2727 Mahan Drive, MS-47
Tallahassee, FL 32308
Phone: (850) 922-6089; Fax: (850) 922-2217

Date report submitted: _____ **Report period:** _____
(i.e.: June 1, 2001 through June 30, 2001)

Assisted Living Facility (ALF) Information

Name: _____ License Number _____

Street Address: _____

City: _____ County: _____ Zip: _____

Phone: _(_____)_____ FAX: _(_____)_____

Monthly Liability Claim Information: Liability claims filed during the report period are listed below, totaling _____ claims (insert number of total claims filed and complete the attached Claim Information about each claim).
Do you have a risk management and quality assurance program? ____Yes ____No

The total number of pages included in this report: _____ (insert number of pages including this page).

Report completed by:

_____ _____ _____
Authorized ALF Representative Name Signature Date

_____ _____
Position Title E-mail Address

Attachments: Specific liability claim information for each claim filed during report period

Page _____ of _____

Assisted Living Facility (ALF) Monthly Liability Claim Information

ALF Name: _____
Report Period: _____

Enter claim information for each claim filed:

Claim Information

Name of resident: _____

Social Security Number: _____

Medicaid ID# (if applicable):_____

Incident Date: _____
and/or
Dates of Residency: _____

_____

Type of injury, select all that apply:

____ 1. Death
____ 2. Brain or spinal damage
____ 3. Permanent disfigurement
____ 4. Fracture or dislocation of bones or joints
____ 5. Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives
____ 6. Any condition that required the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident
____ 7. Abuse, neglect or exploitation as defined in Section 415.102, Florida Statutes
____ 8. Events reported to law enforcement; or
____ 9. Elopement
____ 10. Other: _____

Violation alleged:_____

_____

Analyst Comments (AHCA Use Only):

Claim Information

Name of resident: _____

Social Security Number: _____

Medicaid ID#: (if applicable)_____

Incident Date: _____
and/or
Dates of Residency: _____

_____

Type of injury, select all that apply:

____ 1. Death
____ 2. Brain or spinal damage
____ 3. Permanent disfigurement
____ 4. Fracture or dislocation of bones or joints
____ 5. Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives
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____ 10. Other: _____

Violation alleged:_____

_____

Analyst Comments (AHCA Use Only):

Attach additional pages as needed

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