

Assisted Living Facility Monthly Liability Claim Information

Refer to section 400.423(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 that were 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) 414-6936; 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): _____

Date or dates of incident: _____

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) _____

Date or dates of incident: _____

Type of injury, select all that apply:

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- 2. Brain or spinal damage
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Violation alleged: _____

Analyst Comments (AHCA Use Only):

Attach additional pages as needed

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