CONTRACTOR NAME _____ **SYSTEMIC CASE, IF APPLICABLE** _____

NAME OF PERSON WHO CONDUCTED ONSITE VISIT _____ **CONTACT NUMBER OF PERSON WHO CONDUCTED ONSITE VISIT** _____

NAME OF PERSON SUBMITTING FORM _____ **CONTACT NUMBER OF PERSON SUBMITTING FORM** _____

DATE OF HEALTH AND SAFETY ONSITE REVIEW	FACILITY NAME	FACILITY ADDRESS	AHCCCS PROVIDER ID	MEMBER NAME	MEMBER AHCCCS ID NUMBER	DESCRIPTION OF CONCERNS IDENTIFIED DURING HEALTH AND SAFETY REVIEW INCLUDING THE INDIVIDUAL INCIDENT, ACCIDENT, AND DEATH INTERNAL REFERRAL/QUALITY OF CARE (IAD/IRF/QOC) CASE ID WHEN APPLICABLE	ACTION(S) TAKEN [E.G. CORRECTIVE ACTION PLAN (CAP), MONITORING AND FREQUENCY, MOVE MEMBER, BED HOLD]	DATE OF MEMBER MOVE, IF APPLICABLE

Effective Dates: 07/01/16, 09/20/17, 10/01/20, 10/01/21, 10/01/22, 01/01/23, 10/01/24, 10/01/25
Approval Dates: 07/20/17, 08/20/20, 04/29/21, 04/14/22, 10/06/22, 07/17/24, 05/23/25