RCCDC Student Accident Claim Form

In the event of an injury to a child <u>requiring a trip to doctor/medical professional or emergency room</u>, please follow the steps below:

1. Follow RCCDC Emergency Procedures
2. Contact the Parent
3. Notify Grantee/HR Office (Estee Hawkins, Program Coordinator or Susan Spring)
4. Complete the Student Accident Claim Form
   3a. Complete as much information as possible about the child and injury (Part I only) Make a copy of the complete form, preferably with parent signature.
5. Complete the RCCDC Injury / Accident form and licensing Critical/Reportable Incident Form
6. Within 24 hours or the next business day, verbally notify Licensing Section Management staff of the reportable incident. The verbal report must be followed by faxing the Critical/Reportable Incident Form to licensing within 24 hours.

   LDE Licensing
   PO BOX 4249
   Baton Rouge, LA 70821
   225-342-9905
   225-342-2498 (FAX)

7. Fax a copy of Student Accident Claim form, RCCDC Injury/Accident Form and licensing Critical/Reportable Incident Form to the Grantee/HR office (Attention: Estee Hawkins, Program Coordinator or Susan Spring)

Grantee Contacts:

Estee Hawkins
Safety Coordinator
985-318-8800 x 252
985-318-8807 HR fax
985-318-8804 fax
ehawkins@rccdc.org

Susan Spring
Executive Director
985-318-8800

Ola McGee
Program Coordinator
985-318-8800

Kim Harrell
Program Coordinator
985-318-8800

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ILLNESS/INCIDENT/ACCIDENT FORM

Center: _____ Class # _____ Date/Time of Incident: _____ at _____ am/pm

Child's Name _____ Sex: F / M DOB: _____ Reporter: _____

Staff/Witnesses Present: _____ # Of Children at the scene: _____

Location of Incident: _____

- [ ] Classroom # _____
- [ ] Bus # _____
- [ ] Bathroom Location: _____
- [ ] Hallway/Doorway _____
- [ ] Office of _____
- [ ] Outdoor Learning _____
- [ ] Field Trip Location: _____
- [ ] Home _____
- [ ] Other: _____

Equipment/Surface Involved

- [ ] Hand toy: _____
- [ ] Surface Type: _____
- [ ] Climber/Slide _____
- [ ] Swing _____
- [ ] Sandbox _____
- [ ] Tricycle/Wagon _____
- [ ] Other: _____
- [ ] Not Applicable

Description of Incident/Accident/Illness:

- [ ] Fall from height of _____ feet
- [ ] Injury due to running / tripping / slipping Describe: _____
- [ ] Child Bite - Area bitten: _____ Was skin broken Yes / No
- [ ] Hit / Push - Describe: _____
- [ ] Choking on object _____
- [ ] _____
- [ ] Motor Vehicle - Describe: _____
- [ ] Heat/Cold Related - Describe: _____
- [ ] Illness Symptoms _____
- [ ] Behavior/Mental Health _____
- [ ] Other: _____

Type of Illness/Incident:

- [ ] Bruise/Swelling
- [ ] Red mark on skin, but skin not broken
- [ ] Scrape/Cut/Puncture
- [ ] Crushing/smashing
- [ ] Burn
- [ ] Vomiting/Diarrhea
- [ ] Fever: _____ at _____ am/pm
- [ ] Loss of Consciousness
- [ ] Unusually Withdrawn/Quiet
- [ ] Excessive/Unusual Crying
- [ ] Excessive/Unusual Aggressive Behavior
- [ ] Other: _____

Part(s) of Body/Location of Injury:

- [ ] Head - Describe location: _____
- [ ] Face
- [ ] Ear: L / R
- [ ] Nose
- [ ] Eye: L / R
- [ ] Tooth/Teeth
- [ ] Mouth
- [ ] Trunk - Describe: _____
- [ ] Arm/Elbow: L / R
- [ ] Wrist/Hand: L / R
- [ ] Fingers - Describe: _____
- [ ] Leg/Knee: L / R
- [ ] Ankle / Foot: L / R
- [ ] Toes - Describe: _____
- [ ] Not Applicable/None
- [ ] Other: _____

PLEASE SEE OTHER SIDE

Action Taken (check all that apply)

- [ ] Specialist Contacted (Name) _____
- [ ] Wound Cleaned with soap & water
- [ ] Band aid/bandage
- [ ] Ice pack applied for ____ minutes
- [ ] Child comforted (hugs/extra attention)
- [ ] Presssure applied to wound
- [ ] Rest
- [ ] Isolation in Office
- [ ] Treatment provided by (staff name) _____
- [ ] Taken to Dr/Hospital by: _____ Provider Name _____ at _____ am/pm (attach report)
- [ ] Licensing Contacted _____ at _____ am/pm via fax/phone within 24 hours
- [ ] Other: _____

Parent Notification of incident:

- [ ] By phone / in person (circle one)
  at _____ am/pm
- [ ] Parent could not be reached (see below)
- [ ] Name of Emergency Contact reached:
  _____
- [ ] Contact made by:(staff signature)
  _____

Corrective action(s) needed to prevent reoccurrence: _____

Staff Signature: _____ Date _____

Parent Signature: _____ Date _____

In charge Signature: _____ Date _____
or/and
Director Signature: _____ Date _____

1st Attempt to contact Parent/Guardian _____ Phone # _____ Time _____

2nd Attempt to contact Parent/Guardian _____ Phone # _____ Time _____

3rd Attempt to contact Parent/Guardian _____ Phone # _____ Time _____

Comments: _____

(Note: Send a copy of any incident that requires doctor's care to Health Specialist.
Send a copy of any incident on the bus to the Facilities/Transportation Manager)

Incidents & Accidents notify parent immediately:

- Blood not contained in a band aid
- Head Injury
- Human bite breaking the skin
- Any animal bite
- An impaled object
- Broken or dislodged teeth
- Any requiring professional medical attention
- Staff notifying parent signs their name

Illnesses & Unusual behavior notify parent:

- Allergic reaction
- Skin changed ..rash,spots,swelling
- Unusual breathing
- Dehydration
- Oral temp over 100, rectal 102, 100 axillary
- Any requiring professional medical attention
- Staff notifying parent signs their name

Revised 05/24/2012

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO

Administrative Concepts, Inc
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1082
www.visit-aci.com

Arch Insurance Group®

PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number: 11SPR8178601	Organization Name: Regina Coeli CDC	Event, Activity or Sport:

Claimant's Name (Injured Person)	~~Social Security Number~~ XXXXXXXXXXXXXXXXX	Gender ☐M ☐F	Date of Birth	E-Mail Address

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	Place where Accident Occurred	The injured person was a: ☐ Participant ☐ Staff Member ☐ Other

Dental Claims	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)	Did Injury Result in Death? ☐YES ☐NO

Describe How Accident Occurred – Provide All Possible Details	Activity Where the Accident Occurred:
	• Day Camp ☐ • Overnight Camp ☐ • League Game or Practice ☐ • Tournament ☐ • Other _____ ☐

Did Accident Occur (Check Yes or No for Each of the Following):

A. On activity premises? ☐YES ☐NO
B. While traveling directly and uninterruptedly to or from the activity? ☐YES ☐NO
C. During a participating organization practice? ☐YES ☐NO
D. During a participating organization competition? ☐YES ☐NO

Signature of Participating Organization Representative	Name and Title of Participating Organization Representative	Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? ☐YES ☐NO

If Yes, name of insurance company::_____ Policy #:_____

Mother's (Guardian's) primary employer name, address & telephone: _____

Father's (Guardian's) primary employer name, address & telephone: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐YES ☐NO If yes, please explain: _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

PART III – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE _____ **DATE** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to ***Arch Insurance Group*** or its designated administrator**.** A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse ***Arch Insurance Group*** to the extent of any amount collectible.

I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _____ **DATE** _____

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR and RI:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime, **specific to PA**: subjects such person to criminal and civil penalties and **specific to NY:** shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Louisiana, New Mexico, Texas and West Virginia: presents a false or fraudulent claim for the payment of a loss (or **specific to LA, TX and W VA**: who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM**: to civil fines and criminal penalties.)

Maryland: and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING:

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine/Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Tennessee and Virginia : It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

7303.F.4 – Class A
7361.M.4 – Class B

LDE Licensing
Phone: (225) 342-9905
Fax: (225) 342-2498

CRITICAL/REPORTABLE INCIDENT FORM

Name of Facility: _____ License Number: _____
Address of Facility:_____ Contact Number: _____

Date of Incident: _____ Time of Incident: _____

Child(ren) Involved in Incident:
_____
_____
_____

Staff involved and other staff present:
_____
_____
_____

Description of Incident: _____
_____
_____

Name of Parent notified: _____ Date of Notification: _____ Time of notification: _____ Signature of staff notifying parent: _____
List any failed attempts to notify a parent (of the incident) below, including the name of the attempted parent, as well as the date and time of each attempt.
1.) _____
2.) _____
3.) _____

Was notification made to emergency personnel and/or law enforcement?
Yes No (circle one)
If Yes, list who was contacted, the date of contact and the time of contact.
1.) _____
2.) _____
3.) _____
Signature of staff notifying emergency personnel/law enforcement: _____

Was Child Welfare contacted? Yes No (circle one)
If Yes, list who was contacted, the date of contact and time of contact:
_____
Signature of staff notifying Child Welfare: _____

Was Licensing contacted? Yes No (circle one)
If Yes, list the name of the person contacted, the date of contact and time of contact:
_____
Signature of staff notifying Licensing Staff:
_____

Corrective Action Taken and/or needed to prevent reoccurrence:
_____
_____

Signature of staff completing this report: _____ Date: _____

Parent Signature: _____ Date: _____ Time: _____