Seclusion and/or Restraint (SAR) Monthly Reporting

Month and Year: ______________________

Agency Name: ______________________

Agency SAR Contact Name: ______________________

Agency SAR Contact Email: ______________________

Complete SECTION 1 or SECTION 2 Below

SECTION 1:

Date of SAR	SAR Location	AHCCCS ID	SAR Type	Injury?	Associated IAD Number (If applicable)

I attest that the above event(s) have been reviewed and reported timely per Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual (AMPM) Policy 962:

____

Medical Director or Designee Signature Date

SECTION 2:

I attest there were no SAR events for review this month:

____

Medical Director or Designee Signature Date

Please submit completed form to MCCAZ-QOC@MolinaHealthcare.com by the 5th of every month

For questions, please contact Molina Quality Management (QM) at MCCAZ-QOC@MolinaHealthcare.com