

INCIDENT REPORT

To document issues that impact the health, safety, welfare, or lifestyle choices of individuals

IDENTIFYING INFORMATION:		<input type="checkbox"/> ABI	<input type="checkbox"/> ABI-LT	<input type="checkbox"/> DCBS	<input type="checkbox"/> Michelle P	<input type="checkbox"/> SCL	<input type="checkbox"/> SGF
Class	Medicaid	Name: _____			Adjudicated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> I	Member ID #: _____						
<input type="checkbox"/> II	DOB: _____	Reporting Agency: _____		Provider Number: _____			
<input type="checkbox"/> III	Reporting Person: _____	Title: _____		Phone: _____			
Case Mgmt Provider: _____		Case Mgr Name: _____					

INCIDENT INFORMATION:																					
Date of <input type="checkbox"/> Incident <input type="checkbox"/> Discovery: / /	Time: _____ am/pm																				
LOCATION OF INCIDENT	REPORTED TO																				
<input type="checkbox"/> Residence <input type="checkbox"/> Job Site <input type="checkbox"/> Day Program <input type="checkbox"/> Home Visit <input type="checkbox"/> Community <input type="checkbox"/> Transportation Broker <input type="checkbox"/> Respite <input type="checkbox"/>	<div style="font-size: small;"> Case Mgr./Sup. Broker: Class I and II-24 hrs/Class III-8 hrs. Guardian: Class I -as directed / Class II and III- 24 hrs. Class III: DCBS-Immediate (if applicable) and DMR: 8 hrs. </div>																				
Address: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"></th> <th style="width: 25%;">Date: / /</th> <th style="width: 25%;">Time: a/p</th> <th style="width: 25%;">Date: / /</th> </tr> </thead> <tbody> <tr> <td>Case Mgr./Support Broker</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Regulating Agency</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Guardian/Individual</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>DCBS</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Date: / /	Time: a/p	Date: / /	Case Mgr./Support Broker	_____	_____	_____	Regulating Agency	_____	_____	_____	Guardian/Individual	_____	_____	_____	DCBS	_____	_____	_____
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Class III - 7 days	_____	_____	_____																		

INCIDENT DETAILS:

What happened immediately before the incident? _____

What happened during the incident? _____

What happened immediately following the incident? _____

If the incident happened again, what would you do differently? _____

Signature of person witnessing the incident _____ Title: _____ Date: _____

INCIDENT CODES (select all that apply)		
<input type="checkbox"/> A - Suspected Abuse	<input type="checkbox"/> H - Suicide Attempt	<input type="checkbox"/> P - Emergency Room Visit
<input type="checkbox"/> B - Suspected Neglect	<input type="checkbox"/> I - Severe Behavior Outburst	<input type="checkbox"/> Q - Hospitalization, Medical
<input type="checkbox"/> C - Suspected Exploitation	<input type="checkbox"/> J - Property Damage	<input type="checkbox"/> R - Hospitalization, Psychiatric
<input type="checkbox"/> D - Death of an Individual	<input type="checkbox"/> K - Self Abuse	<input type="checkbox"/> S - Medication Error
<input type="checkbox"/> E - Emergency Chemical Restraint	<input type="checkbox"/> L - Individual Aggressed to Staff	<input type="checkbox"/> T - Serious Injury
<input type="checkbox"/> F - Emergency Physical Restraint	<input type="checkbox"/> M - Peer on Peer Aggression	<input type="checkbox"/> U - Police Involvement
<input type="checkbox"/> G - Threatened Suicide	<input type="checkbox"/> N - Negative Media Attention	<input type="checkbox"/> V - CMHC Crisis Referral
Other _____	<input type="checkbox"/> O - Elopement	<input type="checkbox"/> W - Urgent Treatment Center Visit

STATE USE - Follow-up Indicator: Cabinet Staff Follow-up Desk Level Investigation On-Site Investigation



INCIDENT FOLLOW-UP

(Add additional pages if necessary)

Social Security Number: _____ Name: _____ Incident Date: _____

Diagnoses: Axis I: _____	Recent Medical Concerns: _____
Axis II: _____	
Axis III: _____	

Does the individual have:

Rights Restrictions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please list rights restrictions: _____
Behavior Support Plan	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Crisis Plan	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Why did this incident occur? (analysis of cause – not restatement of the information on page 1):

Individual Issues	System Issues
How many times has this kind of incident happened with this individual in the past three months?	How many times has this kind of incident happened in your agency in the past three months?
What did you do to keep the person safe and well?	What system(s) or policy(ies) failed to prevent this incident from occurring or contributed to the incident occurring?
What changes will occur in the in the individual's life to prevent the incident from recurring and how will they be documented?	
When will the individual's team meet to consider these changes?	Why did this system or policy not work as was intended?
How should these changes be implemented?	
When should these changes be implemented?	How will the system or policy be changed to prevent recurrence?
Who should ensure these changes are implemented and followed?	
What concerns did the individual express when you talked with them about this incident?	When will the system or policy be changed?
How does the individual report they are doing today?	Who will monitor the system changes to ensure they are implemented and followed?
Signatures:	
Program Director / Supervisor	Signature: _____
Case Manager/Support Broker	Executive Director/MRDD Director