1) Date of Report: mm/dd/yyyy 2) County: the county in which the consumer’s agency of service is located.

3) Incident Date and Time: mm/dd/yyyy; ##:## am/pm 4) Date and Time known to Agency: mm/dd/yyyy;\_##:## am/pm

5) Alleged Victim Name(s): First and last name(s) If something happens to the individual they are considered a victim (i.e., if a person fell, they are considered a victim; went to the hospital; someone assaulted them, etc.)

6) Alleged Perpetrator Name(s) (if applicable) and relationship to victim: First and last name(s) If, as a result of their own actions and incident occurs such as the individual does something to themselves or someone less they are considered a perpetrator (i.e., if the individual fell because they were chasing someone; if the individual elopes/walks away)

7) Identified witnesses (if applicable): First and last name(s) A person who was directly there and saw the event and their title (consumer, staff, family, etc.)

8) Location of Incident: where the incident occurred.

9) Reporting Agency Name, Address & Program Element: Full (unabbreviated) name, #### Street Name, State, Zip Code of agency and program element (s) the consumer is currently receiving (e.g., Residential, Supported Housing, RIST, Partial Care, Outpatient, IOTSS, EISS, PACT, ICMS, PES, IOC, Supported Employment, Supported Education, PATH, JIS, POST, Short Term Residential SA Treatment, Long Term Residential SA Treatment, Halfway House, Residential Detox (Non Hospital & Hospital), Extended Residential Care, Partial Care SA Treatment, Outpatient SA Treatment, Intensive Outpatient SA Treatment, Outpatient Ambulatory Detox (Non Hospital), Opiate Treatment Program).

10) Type of Incident: (**check all appropriate categories**) These are general categories, don’t be concerned if you are not sure how to categorize the incident; the UIR Coordinator will be able to categorize the incident from the detailed description of the incident.

Death, Expected

Death, Sudden and Unexpected

Alleged Suicide Attempt

Alleged Physical Abuse

Alleged Physical Assault (Moderate/Major Injury)

Alleged Sexual Abuse

Alleged Sexual Assault

Medical

Sexual Contact

Rights Violation

Alleged Exploitation

Alleged Neglect

Alleged Verbal/Psychological Abuse

Criminal Activity

Elopement/Walkaway

Injury (Moderate/Major)

Overdose

Media Interest

Operational

Contraband(for substance use providers only)

11) Provide a detailed description of incident being reported: please give a full description of details regarding this incident (including dates, times, locations, full names of hospitals/facilities/agencies involved just before, during, and just after the incident).

**Consumer(s) Involved**

Complete all information below **for each individual consumer involved** in this incident (attach additional sheets if needed).

1) First Name:       Last Name:

2) Date of Birth: mm/dd/yyyy 3) Gender: Male/Female

4) Phone: ###-###-####

5) Address: #### Street Name, State, Zip Code where the consumer currently resides

6) The role of the aforementioned consumer:  Alleged Victim  Alleged Perpetrator

7) Was this consumer on agency site or in presence of staff at the time of this incident?  Yes  No

If Yes: Agency Name: Full (unabbreviated) agency name

Agency Site/Address: #### Street Name, State, Zip Code

Agency Program Element: program element the consumer where incident occurred (e.g., Residential, Supported Housing, RIST, Partial Care, Outpatient, IOTSS, EISS, PACT, ICMS, PES, IOC, Supported Employment, Supported Education, PATH, JIS, POST, Short Term Residential SA Treatment, Long Term Residential SA Treatment, Halfway House, Residential Detox (Non Hospital & Hospital), Extended Residential Care, Partial Care SA Treatment, Outpatient SA Treatment, Intensive Outpatient SA Treatment, Outpatient Ambulatory Detox (Non Hospital), Opiate Treatment Program).

8) Consumer’s Residential Service Provider’s information: This is for Mental Health Agencies only and information refers to residential services

Level of care:  A+,  A,  B, or  C

Agency Name: Full (unabbreviated) agency name

Agency Site/Address: #### Street Name, State, Zip Code

Agency Program Element: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9) Is this consumer also served by the New Jersey Division of Developmental Disabilities (DDD)?  Yes  No

If Yes: Case Manager Name: First and last name

Case Manager Contact Information: ###-###-#### and/or e-mail address

10) Identify other services (within or outside your agency) that this consumer is involved in, including MH and/or SUD:

Agency Name: Full (unabbreviated) agency name Agency Site/Address: #### Street Name, State, Zip Code Agency Program Element: other program elements the consumer is involved in

11) How long has this consumer been receiving services from your agency (include date of admission)?

## years, ## months (since mm/dd/yyyy)

12) How often is this consumer seen by your agency? 24/7? Daily? Weekly? Monthly? Every ## days/weeks/months?

The consumer’s scheduled number of hours ## and scheduled number of days per week ##.

The consumer’s actual number of hours of attended ## and actual number of days attended per week ##.

13) When was this consumer last seen by your agency PRIOR to the incident? (Prior to the incident is important, not after the incident occurred) mm/dd/yyyy

14) Has this consumer been discharged within the last 60 days from a STCF, CCIS, state, county or private psychiatric hospital or another community mental health agency?

No  Yes, specify the hospital name and discharge date: mm/dd/yyyy; hospital name (indicate what type of hospital)

15) Does this consumer have any legal/criminal status?

No  Yes, specify status: e.g., CEPP, Detainer, Involuntary, IST, KROL, Megan’s Law, Voluntary, NGRI, Drug Court, Intoxicated Driver Resource Center, Parole, or Probation.

16) Diagnoses:

DSM Diagnoses: full diagnoses descriptions (numbers are **not** to be included; e.g., Schizophrenia, Substance Use Disorder)

Medical Diagnoses: full diagnoses descriptions (numbers are **not** to be included; e.g. Hypertension)

17) ASAM Level of Care: Substance Use ONLY (e.g., Outpatient Detox, Outpatient Methadone, Intensive Outpatient Detox, Intensive Outpatient Services, Partial Care, Halfway House, Extended Care, Long Term Residential, Short Term Residential, Non-Hospital Based Detox, Detox Hospital Bed).

18) Medications:

Psychiatric Medications: full brand or generic psychiatric drug names (e.g., Sertraline, Zoloft).

Medical Medications: full brand or generic medical drug names (e.g., Lisinopril for high blood pressure, Simvastatin for High Cholesterol), Methadone.

19) Notifications, including family, local law enforcement, court and Prosecutor’s Office:

Name: First and last name(s) Title:       Date: mm/dd/yyyy Time: ##:##

20) Immediate actions taken or other actions planned (include responsible party):

Actions the agency is taking or planning to take immediately in response to this incident (e.g., administrative review, policy/procedure change, root cause analysis, increased consumer monitoring/supervision, further investigation, involuntary commitment, maintenance/repair, psychiatric hospital admission, staff counseling, staff disciplinary action, staff training, staff suspension, staff termination).

This document was prepared by: First and last name Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: mm/dd/yyyy Time: ##:## Phone number: ###-###-#### E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact person if different than the preparer (include as many individuals as necessary to remain in the incident reporting loop) : First and last name Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: ###-###-#### E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Note: e-mail address(es) listed here will be sent notification from DMHAS.)