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| **PROVIDER INFORMATION** |
| **Provider Name**: Click or tap here to enter text. |  | **Incident Report Contact**: Click or tap here to enter text. |
| **Provider Federal Tax ID (FID) #**: Click or tap here to enter text. |  | **Title**: Click or tap here to enter text. |
| **Site Address**: Click or tap here to enter text. |  | **Contact Number**: Click or tap here to enter text. |
| **City/ State/Zip**: Click or tap here to enter text. |  | **Email Address**: Click or tap here to enter text. |
| **County of Program**: Click or tap here to enter text. |  | **Service(s) Provided:** Click or tap here to enter text. |

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| **INCIDENT DESCRIPTION** |
| **Incident Date and Time**: | Click or tap here to enter text. |  | **Date and Time Known to Provider**:  | Click or tap here to enter text. |
|  | [ ]  **Unknown** |
| **Location of Incident**: | Click or tap here to enter text. |
| **Was this consumer *on agency site* or** ***in presence of staff* at the time of this incident?** [ ]  **Yes** [ ]  **No** |
| **Allegation *and/or* Event: (Check *all* appropriate categories. Refer to Categories Grid for definitions.)** |
| **Allegations** | **Events** |
| [ ] Abuse: Physical Choose an item. | [ ] Death Choose an item. |
| [ ] Abuse: Verbal/Psychological | [ ] Medical Choose an item. |
| [ ] Abuse: Sexual | [ ] Suicide Attempt Choose an item. |
| [ ] Neglect Choose an item. | [ ] Overdose |
| [ ] Exploitation: Financial Choose an item. | [ ] Injury (Moderate) Choose an item. |
| [ ] Exploitation: Personal | [ ] Injury (Major) Choose an item. |
| [ ] Professional Misconduct | [ ] Elopement/Walkaway |
| [ ] Rights Violation | [ ] Physical Assault Choose an item. |
| [ ] Sexual Assault | [ ] Operational Choose an item. |
|  | [ ] Criminal Activity Choose an item. |
|  | [ ] Contraband Choose an item. |
|  | [ ] Unapproved Restraint Choose an item. |
| Provide a **detailed** description of the incident being reported: Click or tap here to enter text. |

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| **CONSUMER INFORMATION:** [ ]  **ALLEGED VICTIM (AV)** [ ]  **ALLEGED PERPETRATOR (AP)** |
| **First Name**: Click or tap here to enter text. | **Last Name**: Click or tap here to enter text. |
| **Date of Birth**: Click or tap here to enter text. | **Gender**: Click or tap here to enter text. |
| **Home Address**: Click or tap here to enter text. | **Residential Level of Care** *(If applicable):* [ ]  A+ [ ]  A [ ]  B |
| **Type of Service(s) Received**: [ ]  Mental Health [ ]  SUD | **ASAM Level of Care** *(If applicable):* Choose Level of Care |
| **List Service(s) Received:** Click or tap here to enter text. | **Type of CSS** *(If applicable):* Choose Type of CSS |
| **The service(s) identified above are** [ ]  Licensed [ ]  Contracted | **DDD Consumer**: [ ] Yes [ ] No**Support Coordinator Name/Agency**: Click or tap here to enter text. |
| **ICD 10 MH/SUD Diagnoses Code**: Click or tap here to enter text. |
| **Psychiatric/MAT Medications:** Click or tap here to enter text. |
| **ICD 10 Medical Diagnosis Code**: Click or tap here to enter text. |
| **Medical Medications**: Click or tap here to enter text. |
| **Legal/Criminal Status**: [ ]  Yes [ ]  No | **Type**: [ ]  KROL [ ]  Recovery Court [ ]  Parole [ ]  Probation [ ]  Megan’s Law [ ]  Detainer [ ]  IST [ ]  IOC  |
| Was the consumer discharged from any inpatient or outpatient mental health or substance use treatment within the last 30 days? [ ]  Yes [ ]  No If yes, please identify the facility and the date of discharge: Click or tap here to enter text. |

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| **MH/SUD SERVICE(S) PROVIDED *(include additional providers, if applicable)*** |
| **SERVICE 1** | **SERVICE 2** | **SERVICE 3** |
| **Provider Name**: Click or tap here to enter text. | **Provider Name**: Click or tap here to enter text. | **Provider Name**: Click or tap here to enter text. |
| **Date of Admission**: Click or tap here to enter text. | **Date of Admission**: Click or tap here to enter text. | **Date of Admission**: Click or tap here to enter text. |
| **Service**: Click or tap here to enter text. | **Service**: Click or tap here to enter text. | **Service**: Click or tap here to enter text. |
| **Scheduled Days & Hours**: Click or tap here to enter text. | **Scheduled Days & Hours**: Click or tap here to enter text. | **Scheduled Days & Hours**: Click or tap here to enter text. |
| **Seen as Scheduled** [ ]  Yes [ ]  No | **Seen as Scheduled** [ ]  Yes [ ]  No | **Seen as Scheduled** [ ]  Yes [ ]  No |
| **Date last seen (prior to incident)**: Click or tap here to enter text. | **Date last seen (prior to incident)**:Click or tap here to enter text. | **Date last seen (prior to incident)**:Click or tap here to enter text. |
| Additional Comments: Click or tap here to enter text. |

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| **STAFF ALLEGED PERPETRATOR (AP) INFORMATION *(if applicable)*** |
| **Full Name**: Click or tap here to enter text. | **Title**: Click or tap here to enter text. |
| **Is this staff Licensed/Certified?** [ ] Yes [ ] No | **License/Certification Type & Number** *(if applicable)*: Click or tap here to enter text. |

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| **WITNESS/OTHER INFORMATION** ***(if applicable)*** |
| **Name(s) and Title(s)**: Click or tap here to enter text. |

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| **NOTIFICATIONS**List notifications made **outside** your agency (i.e. Family, Law Enforcement, Recovery Court, Parole/Probation, DOH, Professional Licensing Board, Case Manager/Support Coordinator, Additional Provider, APS, DCF, etc.) |
| Have all appropriate parties been notified? [ ] Yes [ ] No |
| **NAME** | **TITLE** | **DATE/TIME** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

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| **ACTIONS TAKEN/PLANNED**Indicate the immediate actions taken and/or planned. Include a description/further details in the space provided below (i.e. name of hospital, treatment received, referral information, name of training, type of disciplinary action, etc.) |
| [ ] Further Investigation (To begin within 24hrs and be completed by an objective party) | [ ] ER Treatment/Evaluation/Screening Hospital |
| [ ] Protective Actions | [ ] Administered Naloxone |
| [ ] AV [ ] AP transferred | [ ] Medical or Psychiatric/Behavioral Hospitalization |
| [ ] Disciplinary action(s) | [ ] Follow Up with Doctor |
| [ ] Staff Training | [ ] Referred to Higher Level of Care |
| [ ] Referred to Professional Licensing Board | [ ] Administrative Detox |
| [ ] Review [ ] Revision of Agency Policy & Procedure | [ ] Consumer Discharged |
| [ ] Counseling Consumer/Staff | [ ] Contraband Confiscated/Disposed |
| [ ] Monitoring Consumer/Staff | [ ] Maintenance/Repairs |
| [ ] Treatment Plan Change/Behavioral Contract | [ ] Relocation |
| [ ] Communicable Disease Specific Actions (i.e. actions taken to prevent further spread) |
| [ ] Other (Please specify) Click or tap here to enter text. |
| Detailed description of actions taken/additional information: |
| Click or tap here to enter text. |

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| The information contained in this report is confidential. This document is for internal use only and is not a public document. Only those with a need to know and authority to review this report may review the report. This report may contain confidential client information, as well as protected health information, which are protected by state and federal confidentiality laws. Unauthorized disclosure of any of the contents of this report may result in civil and/or criminal penalties.***If you have received this in error, please call 1-800-382-6717 immediately.*** |