|  |  |  |
| --- | --- | --- |
| CONFIDENTIAL |  | Reportable Event**Department of Intellectual and Developmental Disabilities** |
| Name of Person Supported |       | SSN |       | Date of Event |   /  /     |
| Please Type | Last, First, MI |  | Time of Event |   :   am ☐ pm ☐ |
| Region |  | Provider Responsible |  | Provider Code |  | Provider Reporting (if different) |
| M |  |       |  |       |  |       |
| This event was ☐ Witnessed by  or ☐ Discovered |
| Where event occurred | Address / Site of Event |       |
| Check one | ☐ Home – Inside ☐ Home - Outside ☐ Vehicle ☐ Day Program/Work/School |
|  | ☐ Community-Supervised ☐ Community-Unsupervised ☐ Unknown |
| * **This event required ** Check all that apply
 |
| **☐** Hospital Emergency Room | **☐** Manual Restraint | **☐** MH Mobile Crisis Team | **☐** Police | **☐** 911 Call |
| **☐** X-ray (to rule out fracture) | **☐** Mechanical Restraint | **☐** Emergency Psychotropic Medication | **☐** Incarceration |  |
| **☐** Hospitalization - Medical | **☐** Protective Equipment | **☐** Hospitalization - Psychiatric | **☐** Abdominal Thrust (Heimlich) | **☐** CPR |
| Type of event |  |
| **All BOLDED types must be reported to DIDD Hotline as soon as possible, but within 4 hours:** |
| **☐ Alleged Neglect** (when medical intervention/treatment is necessary) |
| **☐ Alleged Physical Abuse** (when medical intervention/treatment is necessary) |
| **☐ Alleged Sexual Abuse** |
| **☐** **Death** (when unexpected or unexplained) |
| **☐ Serious Injury of Unknown Cause** |
| **☐ Suspicious Injury** (when medical intervention/treatment is necessary) |
| **The remaining types of events are reportable to DIDD Incident Management within 1 business day:** |
| ☐ Alleged Emotional/Psychological Abuse (when there is no intervention, i.e. police, mobile crisis, hospitalization, etc.) |
| ☐ Alleged Exploitation: ☐ greater than $1,000 ☐ $1,000 or less ☐ exploitation of a person supported |
| ☐ Alleged Neglect (when there is no medical intervention) |
| **☐** Alleged physical abuse (when there is no medical intervention/treatment. However, the agency shall place the alleged perpetrator on administrative leave or in a position that does not involve direct contact with, or supervision of, any person supported or supervision of other staff who provide direct care.) |
| **☐** Reportable Behavioral/Psychiatric Event | **☐** Sexual Aggression | **☐** Missing Person (> 15 minutes) |
| **☐** Reportable Medical Event | **☐** Criminal Conduct | **☐** Other Type of Event, specify       |
| **☐** Reportable Staff Misconduct – No injury and risk is minimal because       |
| Brief description of event - (what/where/when/who)  |
|       |
|  |
|  |
| * **Description of injury** to Person Supported: If applicable. Describe type, size, color, location on body; location of treatment; etc.
 |
|       |
| If this is a reportable behavior/psychiatric event involving physical aggression, self-injurious behavior or property destruction; did anyone other than the person served require treatment beyond first aid? |
| ☐ Housemate | ☐ Staff | ☐ Private Citizen/Other |
| Additional Information to clarify this event such as staffing requirements, LON and/or medical diagnosis:       |
| **☐** No Apparent Injury | **☐** Minor Injury |
| ☐ Serious Injury - Fracture, dislocation, traumatic brain injury (concussion), laceration requiring sutures or staples (or Dermabond used in place of sutures), torn ligaments, 2nd and 3rd degree burns, loss of consciousness, sprain or strain (if moderate or severe). Other injuries may also be considered to be serious based on severity, location on the body, etc. |
| Notified | **☐** LegalRepresentative | **☐** ISCProvider | **☐** APS 888-277-8366DCS 877-237-0004  | **☐** Law Enforcement Agency      | **☐** DIDD Investigations888-633-1313 |
| Date &Time |   /  /  **:   am ☐ pm ☐** |   /  /  **:   am ☐ pm ☐** |   /  /  **:   am ☐ pm ☐** |   /  /  **:   am ☐ pm ☐** | Investigator’s Name      |
| Notified | **☐** Chief Officer / AOD(Public ICF/ID) | **☐** Regional Office AOD866-925-4204 | Date/Time |
| Date &Time |   /  /  **:   am ☐ pm ☐** |   /  /  **:   am ☐ pm ☐** |   /  /  **:   am ☐ pm ☐** |
| Person Writing This Report | Print Name/Title: |       /       |
| Date /Time completed: |   /  /     @ **:   am ☐ pm ☐** | Signature: |  |
| * ***Incident Management Coordinator Review***
 | Reviewed by (Name/Title):      ,       |