

Middle Initial:
BSU#:
MR Diagnosis:
Gender:
Date of Birth (MM/DD/YYYY):
Special Indicator:
Individual's Address
Address Line 1:
Address Line 2:
Address Line 3:
City:
State:
Zip Code:
Living Arrangement:
Living Arrangement Qualifier:
Individual's Supports Coordinator (Last Name,
First Name):

Initiator Information

First Section: Initiator Information
Reporting Entity:
Address Line 1:
Address Line 2:
Address Line 3:
City:
Zip Code:
County:
Phone Number (999) 999-9999:
Email Address:
Initial Reporter (First Name):
Initial Reporter (Last Name):
Incident Point Person (First Name):
Incident Point Person (Last Name):

Incident Classification

Incident Occurred or Recognized/Discovered
Date (MM/DD/YYYY):
Incident Occurred or Recognized/Discovered
Time (HH:MM AM/PM):
Provider Location:

Reporting Site County:
Primary Category of Incident:
Secondary Category of Incident:
Incident is a result of Choking or Falling:
Continue with Investigation
Certified Investigator:
CERTIFIED INVESTIGATOR SYSTEM
ENTRY DATE (MM/DD/YYYY):

Actions Taken To Protect Health and Safety

First Section: Actions Taken To Protect Health, Safety, and Rights

Action taken to protect the individual (Describe administrative, health/safety, treatment and targeted individual actions taken to address the incident to date.):

Was CPR administered?

Were supports offered to the victim?

What services were offered to support the victim?

Medical Attention Given

Police Contacted

Emotional Counseling

Were there any other supports?

Other Supports (Please Explain):

Incident Description

First Section: Incident Description

Please describe in detail exactly what happened during the incident. Include dates, times, and all people involved including staff. Include all relevant details prior to, during, and after the incident. Indicate the current status of the individual. (Please save data at least every 10 minutes to prevent session expiration.):

What service/program was the person participating in when the event occurred?

Is incident location known ?

Type of location:

In what physical location did the event occur?

Other, Specify:

Location Name (If any):

Please list all individuals involved:

Address Line 1:

Address Line 2:

Address Line 3:

City:

State:

Final Section

Witnesses

Final Section: Witnesses

Were there witnesses to the incident?

Witness (First Name):

Witness (Last Name):

Relation to individual:

Telephone Number (999) 999-9999:

Target Information

Final Section: Target Information

Is / Was there a Target identified?

Target Identifier:

Target relationship to the individual:

What is the current status if target is identified?

Notification

Final Section: Notification

List each Notification made, excluding those made through HCSIS.

Has Notification been made or will Notification be made?

Family/Agency:

If other, please specify:

Notified/Will Notify:

Person Notified (First Name):

Person Notified (Last Name):

Date Notified (MM/DD/YYYY):

Person Making Contact (First Name):
Person Making Contact (Last Name):
If no Family Notification, please explain:

Additional Information / Optional Categorization

Final Section: Additional Information /
Optional Categorization

Cause:

Effect:

Body Parts:

Diagnosis or Underlying Condition

Other, Please Specify Condition or Symptoms:

Any updated or corrected information from the Incident Description page of the First Section including dates, times, people involved, and relevant details prior to, during, and after the incident. Indicate the current status of the individual. If law enforcement has been contacted please list details of actions taken by law enforcement. (Please save data at least every 10 minutes to prevent session expiration.):

Did the Victim accept the services offered?

If yes, clarify.

Use the following fields to further categorize the incident. A template of values for the codes is available from OMR, or Providers may develop their own values for the codes.

Optional Field 1:

Optional Field 2:

Optional Field 3:

Optional Field 4:

Corrective Action

Final Section: Corrective Action in Response
to the Incident

Describe each corrective action step that has been or will be taken in response to the incident and/or the investigation including modifications to the individual's plan:

Is there a corrective action for this incident?

Corrective Action:
Description of Corrective Action:
Completed / Expected Completion Date
(MM/DD/YYYY):
Responsible Party (First Name):
Responsible Party (Last Name):

Verification of Time and Categorization

Incident Occurred or Recognized/Discovered
Date (MM/DD/YYYY):
Incident Occurred or Recognized/Discovered
Time (HH:MM AM/PM):
Primary Category of Incident:
Secondary Category of Incident:
Incident is a result of Choking or Falling:
Continue with Investigation
Certified Investigator:
CERTIFIED INVESTIGATOR SYSTEM
ENTRY DATE (MM/DD/YYYY):
Investigation Information
Indicate investigation determinations:
As a result of the investigation, is this a case of
founded abuse or neglect?
Has the family been notified of the outcome of
the investigation?
As a result of a Not Approved Management
Review, enter any necessary updates,
clarifications, and corrections.

County Management Review

County Management Review :- Investigation Determinations

County
Investigation Not Required, Not Desired by
County.
Continue with investigation?:
Certified Investigator:
Indicate investigation determination:
As a result of the investigation, is this a case of
founded abuse or neglect?:

Concur with Provider Investigation?:
If No, Please Explain:

County Management Review :- Management Review Details

Approval Status:
Reason:
Follow Up Date (MM/DD/YYYY):
Comments/Recommendations:
Last Edit Date:
Last Editor:

Regional Management Review

Regional Management Review :- Investigation Determinations

Region
Investigation Not Required, Not Desired by
Region.
Continue with investigation?:
Certified Investigator:
Indicate investigation determination:
As a result of the investigation, is this a case of
founded abuse or neglect?:
Concur with Provider Investigation?:
If No, Please Explain:

Regional Management Review :- Management Review Details

Approval Status:
Reason:
Follow Up Date (MM/DD/YYYY):
Comments/Recommendations:
Last Edit Date:
Last Editor:

You are presently logged
into HCSIS

Thursday, October 03,
2013 1:58 PM

Your session will expire at
approximately 2:58 PM