**Incident Details**

Today’s Date      /     /20      Person Reporting

Phone Number (       )      -      MH Waiver Agency Name

Date of Incident      /     /20      Time of Incident      :     AM / PM

Location of Incident  Client Residence  Community  Office/Facility  Nursing Home

**Client(s) Involved in Incident**

Client Name       Client Medicaid ID or SSN

Client Date of Birth /     /\_\_19

Client’s role in the incident?  Victim  Perpetrator  Other (specify)

**Incident Category** (check all that apply)

**Client Abuse Alleged**

Physical Abuse Alleged

Verbal Abuse Alleged

Violation of client’s rights

Breach of client’s confidential information

**Death**

Suicide

Homicide

Accident

Accidental Overdose (resulting in death)

Medical Error

Illness, Age or Medical Reason

Insufficient information at this time

**Property Damage**

Property Damage

**Emergency Evacuation/ Notification**

Fire

Bomb

Secret Service

FBI

Other

**Medical Event**

Accidental Injury

Accidental Overdose (did not result in death)

Medication Error/Reaction

Medical Event- Other

**Missing Client**

Missing, Risk to self or others

Missing, no known risk

**Serious Crime Alleged**

Physical Assault

Sexual Assault

Risk of Injury to Minor

Arson

Firearms

Hostage

Drug Sale/Distribution/Posession

Homicide/Manslaughter

**Serious Suicide Attempt**

Suicide Attempt by Active Participant

Suicide Attempt within 30 days of Discharge from Mental Health Waiver

**Threats**

Threats to Agency

Threats to Person

**Other**

Other incident (please specify)

**Please check any substances that were present at the incident**

Alcohol

Prescribed Medication

Illicit Drug(s)

Over-the-counter Medication

No Evidence of substances being present

**Is it likely that this incident will cause media coverage?**

Already Reported  Likely or possible that it will be reported  Not likely to be reported

**Please describe the events of the incident, specifying individuals involved and why incident occurred**