**Incident Details**

Today’s DateClick or tap to enter a date.Person Reporting Click or tap here to enter text.

Phone Number Click or tap here to enter text.E-mail Address Click or tap here to enter text.

MH Waiver Agency Name Click or tap here to enter text.

Date of Incident Click or tap to enter a date.Time of Incident Click or tap to enter a date.

Location of Incident (check all that apply): [ ]  Client Residence [ ]  Community [ ]  Office/Facility [ ]  Nursing Home

**Client(s) Involved in Incident**

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Medicaid ID or SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Date of Birth Click or tap to enter a date.

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/Possession

[ ]  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**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_