PROVIDER INFORMATION

Corporation: _____

NAME

Name and Title of Person completing this form: _____

TITLE

_____

Local Facility/Unit/Group Home

NPI Number: _____

Name: _____

License Number: _____

Director: _____

Physical Address: _____

_____

Mailing Address: _____

_____

City: _____ **Zip Code:** _____

Phone Number: ( ) -

Fax Number: ( ) -

E mail address: _____

County where services provided: _____

Host LME:

County of Residence: _____

Home LME:

INCIDENT INFORMATION

Date and Location

Date of Incident: _____ o **Unable to determine at this time**

Time of Incident: _____

Date Provider Learned of Incident: _____

Was the consumer under the care of the reporting provider? m Yes m No m N/A

Was a Licensed Residential Service being provided? m Yes m No m N/A

Location of the Incident:

- m Consumer's Home
- m Friend's home
- m Group home/Supported living facility
- m Home of Family Member
- m Hospital
- m School
- m Service facility
- m State Facility
- m Work
- m Unknown
- m Other
- m Community

Explain 'Other' in Comments _____

_____

_____

Other People Involed:

- o Friend
- o Friend of Family
- o Other Consumer
- o Family Member
- o Staff
- o Stranger
- o No one
- o Unknown
- o Other

Explain 'Other' in Comments _____

_____

_____

Does this incident include an allegation against the facility? m Yes m No

Will this allegation require a submission of a Consumer Incident Report? m Yes m No

Service Types Provided At the Time of the Incident:

Was the consumer under the care of the reporting provider? m Yes m No m N/A

Was a Licensed Residential Service being provided? m Yes m No m N/A

Service: _____

License#: _____

Was a Non-Residential Licensed Service being provided? m Yes m No m N/A

Service: _____

License#: _____

Was an Un-Licensed Service being provided? m Yes m No m N/A

Service: _____

CONSUMER INFORMATION

First MI Last

Consumer's Name: _____ ___ _____

Address where Incident Occurred: o Address Unknown

Address1: _____

Address2: _____

City: _____

State: _____ **Zip:** _____

Location: _____

LME Client Record Number: _____

Consumer's Date of Birth: _____ o Date of Birth unknown

Gender: m Male m Female

Height: _____ ft _____ in o Unknown

Weight: _____ lbs o Unknown

Dates of Last 2 Medical Exams: _____ o None _____ o None

Diagnoses: Enter up to 5 different diagnoses starting with the primary diagnosis.

_____

_____

_____

_____

_____

Current Medications:

_____

_____

_____

Medical Diagnosis:

_____

_____

_____

Does consumer have TBI (Traumatic Brain Injury)? m Yes m No m Unknown

Is consumer receiving ICF-MR/DD services? m Yes m No m Unknown

Does consumer receive CAP-MR/DD funding? m Yes m No m Unknown

Comprehensive Waiver?	m Yes	m No	m Unknown
Supports Waiver?	m Yes	m No	m Unknown
Self-Directed Waiver?	m Yes	m No	m Unknown
Innovations Waiver?	m Yes	m No	m Unknown

Is this person in the Money Follows the Person program? m Yes m No m Unknown

Treatments

Did this incident result in or is it likely to result in permanent physical or psychological impairment? m Yes m No

Has this incident resulted in or is it likely to result in a danger to or concern to the community or a report in a newspaper, television or other media? m Yes m No

Was the consumer treated by a licensed health care professional for the incident? m Yes m No m Unknown _____ Date

If hospitalized ...

was it for a medical condition? m Yes m No m Unknown _____

was it for a MH/DD/SAS issue? m Yes m No m Unknown _____ Date

Is the consumer enrolled in an opioid treatment program, (methadone maintenance)? If 'Yes', complete the entries in the following box. m Yes m No

Methadone Maintenance

1. Date of Admission to Methadone Maintenance Treatment _____

2. Date of Initial Methadone dosage _____

3. Initial Methadone dose received _____ mg

4. Date of last Methadone dosage prior to incident: _____

5. Last Total Methadone dose received prior to death

			mg	Date
Dosed at Clinic?	m Yes	m No	_____	_____
Given Take-Homes?	m Yes	m No	_____	_____

6. Total Methadone dose received on the date of death (if different from above)

Dosed at Clinic?	m Yes	m No	_____	_____
Given Take-Homes?	m Yes	m No	_____	_____

7. Name of consumer's methadone treatment center physician _____

Mental Health Services

Did the consumer receive mental health services? If so, make the appropriate selections from those available below. m Yes m No

Licensed Residential Services

- o .4300 - Therapeutic Community
- o H0019 (.1700) - Child and Adolescent Residential Treatment - Levels III [Behavioral Health - Long Term Residential
- o H0019 (.1800) - Child and Adolescent Residential Treatment - Levels IV [Behavioral Health - Long Term Residential
- o H2020 (.1300) - Child & Adolescent Residential Treatment - Level II Group - Program Type
- o S5145 - Child and Adolescent Residential Treatment - Level II - Family Type (Licensed by DSS- 131D)
- o Y 2347/ H0046 - Therapeutic Foster Care (licensed by DSS)
- o YA230 (.1900) - Psychiatric Residential Treatment Facility [PRTF]
- o YA241 (.5200) - Wilderness Camp
- o YM725,811-816,YP710, - IPRS Only Licensed Supervised Living (.5600)
- o YM725,811-816,YP710,YP720 - Supervised Living Alternative Family Living (.5600F)
- o YM725,811-816,YP710,YP720 - Supervised Living Adult MH (.5600A)
- o YM755, 740, 750 - IPRS Only Licensed Family Living (.5600)
- o YP485 (.5000) - Facility Based Crisis Program - Non-Medicaid
- o YP760, 770, 780 - IPRS Only Licensed Group Living (.5600)
- o YP820 (.6000) - Inpatient Hospitalization

Licensed Services

- o H0035 (.1100) - Partial Hospitalization - Children and Adults
- o H0035 (.5000) - Professional Treatment Services In Facility-Based Crisis Program
- o H2012 (.1400) - Child and Adolescent Day Treatment
- o H2017 (.1200) - Psychosocial Rehabilitation [PSR]
- o YA125 (.5100) - Hourly Respite [CMSED]- Licensed
- o YA213 (.5100) - Community Respite [CMSED]
- o YP630, YP640 - Supported Employment
- o YP660 (.5400) - Day/Evening Activity
- o YP690 (.5401) - Drop-In Center - Attendance
- o YP692 (.5401) - Drop-In Center - Coverage Hours
- o YP730 (.5100) - Community Respite

Non-Licensed Services

- o - Peer Support Service: B-3 Service
- o .5600 Unlic - Supervised Living Unlicensed

- 0.5700 - Assertive Community Treatment Team [ACTT]
- 90772 - Medication Management
- 90801 - Clinical Evaluation/ Intake
- 90805- 90809 - Individual Therapy
- 90862 - Medication Checks- Individual
- 96101 - Psychological Testing
- H0001 - Behavioral Health Assessment
- H0031 - Mental Health Assessment
- H0032 - Targeted Case Management- MH
- H0036 HA - Community Support: Children/Adolescents
- H0036 HB - Community Support: Adults
- H0036 HQ - Community Support: Group
- H2011 (.6100) - Mobile Crisis Management
- H2015HT - Community Support Team [CST]
- H2022 - Intensive In-Home Services
- H2033 - Multisystemic Therapy
- T1023 - Diagnostic Assessment
- T1023:GT - Diagnostic Assessment- Telemedicine
- Y2345 - Criterion V
- YA125 (.5100) - Hourly Respite [CMSED]-Unlicensed
- YA213 (.5100) - Community Respite [CMSED]
- YM050 - Personal Care Services
- YM580 - Day Supports
- YM600 - Financial Support Services
- YM645 (.5801) - Long-Term Vocational Support- MH/SA
- YM686 - Guardianship
- YM716 - Individual Supports
- YM755, 740, 750 - IPRS Only-Unlicensed Group Living (.5600)
- YM755, 740, 750 - IPRS Only Unlicensed Supervised Living (.5600)
- YM755, 740, 750 - IPRS Only Unlicensed Family Living (.5600)
- YM850 - Residential Supports
- YP010 (.6301) - Hourly Respite - Individual
- YP011 (.6301) - Hourly Respite - Group
- YP020 - Personal Assistance - Individual
- YP230 - Assertive Outreach

- o YP630, YP640 - Supported Employment
- o YP730 (.5100) - Community Respite
- o YP831-834, H0004, HQ, HR, HS - Behavioral Health Counseling & Therapy and Outpatient Treatment
- o YP836 - Mental Health Assessment - Non-Licensed Provider

When did the consumer last receive a mental health service? _____ o N/A

Did the consumer express any suicidal ideation during the last mental health service? m Yes m No

Did the consumer express any homicidal ideation during the last mental health service? m Yes m No

Developmental Disablity Services

Did the consumer receive developmental disability treatment/habilitation services? If so, make the appropriate selections from those available below. m Yes m No

Licensed Residential Services

- o .2100 - Specialized Community Residential Center for Individuals with DD
- o .2101 - Intermediate Care Facility for Persons with MR
- o H0045 - CAP-MR/DD- Respite Care - Institutional
- o H2016 - Innovations Residential Supports Level 1 and Level 1 AFL
- o H2016H1 - Innovations Residential Supports Level 4 and Level 4 AFL
- o S5150US - Innovations Respite- Facility
- o T2014 - Innovations Residential Supports Level 2 and Level 2 AFL
- o T2020 - Innovations Residential Supports Level 3 and Level 3 AFL
- o Y 2347/ H0046 - Therapeutic Foster Care (licensed by DSS)
- o YM725,811-816,YP710, - IPRS Only Licensed Supervised Living (.5600)
- o YM725,811-816,YP710,YP720 - Supervised Living DD Adult (.5600C)
- o YM725,811-816,YP710,YP720 - Supervised Living Alternative Family Living (.5600F)
- o YM725,811-816,YP710,YP720 - Supervised Living Minor DD (.5600B)
- o YM755, 740, 750 - IPRS Only Licensed Family Living (.5600)
- o YP760, 770, 780 - IPRS Only Licensed Group Living (.5600)

Licensed Services

- H0045HI - CAP-MR/DD- Crisis Respite
- S5102 - CAP-MR/DD- Adult Day Health Care Services
- T2021 - CAP-MR/DD- Day Support - Individual
- T2021 - Innovations Day Supports- Individual
- T2021HQ - CAP-MR/DD- Day Support - Group - 2 or More Clients,
- T2027 - Innovations Day Supports Developmental Day
- T202HQ - Innovations Day Supports- Group
- YA213 (.5100) - Community Respite [CMSED]
- YP610 (.2400) - Developmental Day Services
- YP620 (.2300) - Adult Developmental Vocational Program [ADVP]
- YP630, YP640 - Supported Employment
- YP650 (.5500) - Community Rehabilitation Program [Sheltered Workshop]
- YP730 (.5100) - Community Respite

Non-Licensed Services

- .5600 Unlic - Supervised Living Unlicensed
- 90772 - Medication Management
- 90801 - Clinical Evaluation/ Intake
- 90862 - Medication Checks- Individual
- 96101 - Psychological Testing
- H2011 - Innovations Crisis Services Primary Response
- H2011 - CAP-MR/DD- Crisis Services
- H2011 (.6100) - Mobile Crisis Management
- H2014 - Developmental Therapy - Professional - Individual
- H2014HM - Developmental Therapy - Paraprofessional - Individual
- H2014HQ - Developmental Therapy -Professional - Group
- H2014U1 - Developmental Therapy - Paraprofessional - Group
- H2015 - Innovations Community Networking Service
- H2015 - Home and Community Support - Individual
- H2015HQ - CAP-MR/DD- Home and Community Support - Group of 2 or More Clients
- H2015U1 - Innovations Community Networking Class and Conference
- H2015U2 - Innovations Community Networking Transportation
- H2023 - CAP-MR/DD- Long Term Vocational Supports - Individual
- H2023HQ - CAP-MR/DD- Long Term Vocational Supports - Group [2-3 clients]
- H2025 - CAP-MR/DD- Supported Employment - Individual
- H2025 - Innovations Supported Employment Services- Individual

- H2025HQ - Innovations Supported Employment Services-Group
- H2025HQ - CAP-MR/DD- Supported Employment - Group
- NL ADVP - Non-licensed ADVP
- S5110 - CAP-MR/DD- Individual Caregiver Training and Education
- S5110 - Innovations Natural Supports Education- Individual
- S5111 - Innovations Natural Supports Education Conference
- S5125 - CAP-MR/DD- Personal Care Services
- S5125 - Innovations Personal Care Services
- S5150 - Innovations Respite- Individual
- S5150 - CAP-MR/DD- Respite - Non Institutional - Individual
- S5150HQ - CAP-MR/DD- Respite - Non Institutional Nursing - Group [2-3 Clients]
- S5161 - CAP-MR/DD- Personal Emergency Response System
- S5165 - Innovations Home Modifications
- S5165 - Home Modifications
- T 1017 (.5900) - Targeted Case Management [TCM]-DD
- T1005 - CAP-MR/DD- Enhanced Respite Care
- T1005TD - CAP-MR/DD- Respite Care - Nursing - RN
- T1005TD - Innovations Respite Nursing Respite: RN
- T1005TE - CAP-MR/DD- Respite Care - Nursing - LPN
- T1005TE - Innovations Respite Nursing Respite: LPN
- T1015 - Innovations In-Home Intensive Supports
- T1019 - CAP-MR/DD- Enhanced Personal Care
- T1023:GT - Diagnostic Assessment- Telemedicine
- T1999 - CAP-MR/DD- Specialized Equipment and Supplies
- T1999 - Innovations Individual Goods and Services
- T2001 - CAP-MR/DD- Transportation
- T2013 - Innovations In-Home Skill Building- Individual
- T2013HQ - Innovations In-Home Skill Building- Group
- T2014HI - CAP-MR/DD- Home Support - Level 2
- T2016 - CAP-MR/DD- Home Support - Level 5
- T2020HI - CAP-MR/DD- Home Support - Level 3
- T2025 - Innovations Specialized Consultation Services
- T2025 - CAP-MR/DD- Specialized Consultative Services
- T2025-U1 - Innovations Financial Support Services
- T2025U2 - Innovations Employer Supplies

- o T2025-U3 - Innovations Crisis Services Behavioral Consultation
- o T2028 - CAP-MR/DD- Augmentative Communication - Purchases
- o T2029 - Innovations Assistive Technology Equipment and Supplies
- o T2033 - CAP-MR/DD- Home Support - Level 1
- o T2033HI - CAP-MR/DD- Home Support - Level 4
- o T2034 - Innovations Crisis Services Out of Home
- o T2038 - Innovations Community Transition
- o T2039 - CAP-MR/DD- Vehicle Adaptations
- o T2039 - Innovations Vehicle Modifications
- o T2041 - Innovations Community Guide- Monthly
- o T2041 U1 - Innovations Community Guide- Periodic
- o V5336 - CAP-MR/DD- Augmentative Communication - Repairs
- o YA213 (.5100) - Community Respite [CMSED]
- o YM050 - Personal Care Services
- o YM580 - Day Supports
- o YM600 - Financial Support Services
- o YM686 - Guardianship
- o YM700 - Independent Living - MR/MI
- o YM716 - Individual Supports
- o YM755, 740, 750 - IPRS Only-Unlicensed Group Living (.5600)
- o YM755, 740, 750 - IPRS Only Unlicensed Family Living (.5600)
- o YM755, 740, 750 - IPRS Only Unlicensed Supervised Living (.5600)
- o YM850 - Residential Supports
- o YP010 (.6301) - Hourly Respite - Individual
- o YP011 (.6301) - Hourly Respite - Group
- o YP020 - Personal Assistance - Individual
- o YP230 - Assertive Outreach
- o YP630, YP640 - Supported Employment
- o YP730 (.5100) - Community Respite

When did the consumer last receive a development disability service? o N/A

Did the consumer express any suicidal ideation during the last development disability service? m Yes m No

Did the consumer express any homicidal ideation during the last development disability service? m Yes m No

Substance Abuse Services

Did the consumer receive substance abuse services? If so, make the appropriate selections from those available below. m Yes m No

Licensed Residential Services

- o .4300 - Therapeutic Community
- o H0012HB (.3400) - Substance Abuse Non-Medical Community Residential Treatment - Adult
- o H2034 (.3400) - Substance Abuse Medically Monitored Community Residential Treatment
- o H2034 (.5600) - Substance Abuse Halfway House- Licensed
- o H2036 - Medically Supervised or ADATC Detoxification/Crisis Stabilization
- o Y 2347/ H0046 - Therapeutic Foster Care (licensed by DSS)
- o YM725,811-816,YP710, - IPRS Only Licensed Supervised Living (.5600)
- o YM725,811-816,YP710,YP720 - Supervised Living SA Adult (.5600E)
- o YM725,811-816,YP710,YP720 - Supervised Living SA Minor (.5600D)
- o YM755, 740, 750 - IPRS Only Licensed Family Living (.5600)
- o YP760, 770, 780 - IPRS Only Licensed Group Living (.5600)
- o YP790 (.3200) - Social Setting Detoxification
- o YP820 (.6000) - Inpatient Hospitalization

Licensed Services

- o H0010 (.3100) - Non-Hospital Medical Detoxification
- o H0014 (.3300) - Ambulatory Detoxification
- o H0015 (.4400) - Substance Abuse Intensive Outpatient Program [SAIOP]
- o H0020 (.3600) - Opioid Treatment
- o H2012 (.1400) - Child and Adolescent Day Treatment
- o H2035 (.4500) - Substance Abuse Comprehensive Outpatient Treatment [SACOT]
- o YA213 (.5100) - Community Respite [CMSED]
- o YP630, YP640 - Supported Employment
- o YP730 (.5100) - Community Respite

Non-Licensed Services

- o - Peer Support Service: B-3 Service
- o .5600 Unlic - Supervised Living Unlicensed
- o 0.3800 - Substance Abuse Services for DWI Offenders
- o 0.3900 - Drug Education Schools
- o 0.4000 - Treatment Alternatives for Safer Communities (TASC)
- o 90772 - Medication Management
- o 90801 - Clinical Evaluation/ Intake
- o 90805- 90809 - Individual Therapy
- o 90862 - Medication Checks- Individual
- o 96101 - Psychological Testing
- o H0005 (.3500) - Alcohol and/or Drug Services; Group Counseling by Clinician
- o H2011 (.6100) - Mobile Crisis Management
- o T1023:GT - Diagnostic Assessment- Telemedicine
- o YA213 (.5100) - Community Respite [CMSED]
- o YM050 - Personal Care Services
- o YM580 - Day Supports
- o YM600 - Financial Support Services
- o YM645 (.5801) - Long-Term Vocational Support- MH/SA
- o YM686 - Guardianship
- o YM716 - Individual Supports
- o YM755, 740, 750 - IPRS Only-Unlicensed Group Living (.5600)
- o YM755, 740, 750 - IPRS Only Unlicensed Supervised Living (.5600)
- o YM755, 740, 750 - IPRS Only Unlicensed Family Living (.5600)
- o YM850 - Residential Supports
- o YP010 (.6301) - Hourly Respite - Individual
- o YP011 (.6301) - Hourly Respite - Group
- o YP020 - Personal Assistance - Individual
- o YP230 - Assertive Outreach
- o YP630, YP640 - Supported Employment
- o YP730 (.5100) - Community Respite
- o YP830 - Alcohol and/or Drug Assessment - Non-Licensed Provider
- o YP831-834, H0004, HQ, HR, HS - Behavioral Health Counseling & Therapy and Outpatient Treatment
- o YP835 - Alcohol and/or Drug Services; Group Counseling by Non-Licensed Provider

When did the consumer last receive a substance abuse service? _____ o N/A

Did the consumer express any suicidal ideation during the last substance abuse service? m Yes m No

Did the consumer express any homicidal ideation during the last substance abuse service? m Yes m No

Hospital Discharge

Date of last discharge from a State facility/hospital _____ m Never m Unknown

Name of State Facility/Hospital

- o R. J. Blackley ADATC
- o O'Berry Neuro-Medical Center
- o J. Iverson Riddle Developmental Center
- o Black Mountain Neuro-Medical Center
- o Murdoch Developmental Center
- o Julian F. Keith ADATC
- o Cherry Hospital
- o Caswell Developmental Center
- o Central Regional Hospital - Raleigh Campus
- o Longleaf Neuro-Medical Center
- o Walter B. Jones ADATC
- o Central Regional Hospital
- o Broughton Hospital
- o Whitaker School
- o Wright School

Date of last discharge from a Non-State facility/hospital _____ m Never m Unknown

Name of Non-State Facility/Hospital _____

Associated Incident Reports

Have other Incident Reports been submitted for this incident because more than one consumer was involved / affected by this incident? m Yes m No

How many other consumers required, or will require, incident reports for this same incident? _____

Enter the LME Client Record Number or the Consumer's Initials in the spaces below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DEATH INFORMATION

Manner of Death:

Choose One

- m Terminal Illness / Natural Cause
- m Accident
- m Homicide / Violence
- m Suicide
- m Unknown Cause

If 'Suicide' selected above, choose the suicide method from this list.

- m Gunshot
- m Hanging
- m Drowning
- m Stabbing
- m Other

Did death occur within 14 days of discharge from a State Operated Facility? m Yes m No

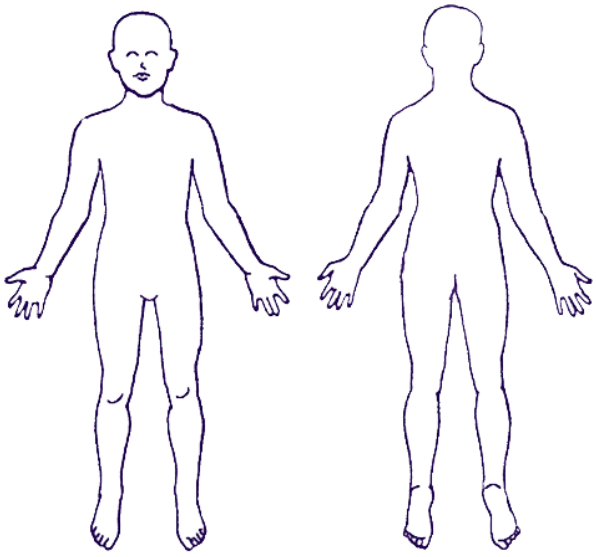
Did death occur within 7 days of Restrictive Intervention? * m Yes m No

Associated Injuries: (Check All That Apply)

- o Airway Obstructed
- o Amputation
- o Bite: Animal
- o Bite: Human
- o Bleeding
- o Broken Bones
- o Bruise
- o Burn
- o Choking
- o Crush
- o Cut/Laceration
- o Dislocation
- o Electrocution
- o Head Injury
- o Ingestion of a Foreign Body
- o Heat/Cold
- o Infection
- o Inhalation
- o Poison
- o Puncture Wound
- o Rash/Hives
- o Scratch
- o Sting
- o Stress/Anxiety
- o Swelling
- o Unknown
- o Other

Explain 'Other' in Comments _____

Associated Body Parts:



Explain 'Other' in Comments _____

_____

_____

Death Due To: (Check All That Apply)

- o Abuse/Neglect/Exploitation
- o Adaptive Equipment
- o Assault
- o Behavioral Outburst
- o Choking
- o Clothing
- o Drowning
- o Drug Overdose
- o Drug Overdose - Methadone Toxicity
- o Eating Behavior/Chewing/Physical Disability
- o Environment
- o Exposure
- o Fall
- o Fire
- o Food Consistency
- o Gunshot
- o Ingestion of Foreign Matter (PICA)
- o Inhalation
- o Insect Bite
- o Medical Procedure
- o Medication Error
- o Motor Vehicle Accident
- o Natural Disaster
- o Poison
- o Restraint Manual/Mechanical
- o Seizure
- o Self-Injurious Behavior
- o Sexual Assault
- o Stabbing
- o Unknown
- o Other

Explain 'Other' in Comments _____

AUTHORITIES AND OTHERS CONTACTED

Authorities or persons you have notified of this incident:

	Contact Name	Phone	Date Notified
o County DSS			
County:			
o Law Enforcement Agency			
Agency Name:			
o Parent/Guardian			
o Clinical Home/Treatment Plan Team			
o			
o			

SUPERVISOR ACTIONS

Level of Incident:

IRIS will determine the level based on the information contained in the incident report.

Describe the cause of this incident:

Describe the cause of this incident, (the details of what led to this incident).

Incident Prevention:

Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident.

Incident Submission:

Name of Supervisor Authorizing Report: _____

Title of Supervisor Authorizing Report: _____

Phone #: _____ **Email Address:** _____

The following checked agencies were notified by providers:

- o Local Management Entity Where Services Provided
- o State Methadone Authority
- o Local Management Entity Where Consumer Resides
- o DMH/DD/SAS Quality Management
- o DMH/DD/SAS Advocacy
- o State Operated Services
- o DHSR Complaint Intake Unit
- o DHSR Healthcare Personnel Registry

When re-submitting the Incident Report, please enter your explanation here.

_____

_____

_____

o By checking this box, I attest that the information contained in this Incident Report is true and an accurate representation of the incident.

Allegations

Report to Health Care Personnel Registry Investigations Branch

Name and Title of person completing this form: _____

Title

_____

Actual Incident Location:

Address1: _____

Address2: _____

City: _____ **Zip:** _____

Type of Facility: _____

Type of Care and Setting: _____

Choose the Type(s) of Allegation Being Made:

- o Resident Abuse
- o Resident Neglect
- o Diversion of Resident Drugs
- o Diversion of Facility Drugs
- o Fraud Against Resident
- o Fraud Against Facility
- o Misappropriation of Facility Property
- o Misappropriation of Resident Property
- o Injury of Unknown Source

Diversion of Resident Drugs Est. Value: _____

Diversion of Facility Drugs Est. Value: _____

Misappropriation of Facility Property Est. Value: _____

Misappropriation of Resident Property Est. Value: _____

Injury of Unknown Source:

Allegation Description:

Additional Resident Information

Did this incident result in physical injury/harm? m Yes m No

Physical Injury/Harm:

Did this incident result in mental anguish lasting 5 days or more? m Yes m No

Diagnoses:

Is the resident interviewable? m Yes m No

Mental Anguish:

Memory & Orientation:

When submitting this Facility Allegation to HCPR, you must enter an explanation here:

Accused Staff

This allegation is being made against how many Staff Members? _____

Staff 1

First MI Last

Staff Full Name: _____ ___ _____

Staff Social Security #: _____

Staff Title: _____

Staff Date of Birth: _____ _____

Staff Home Phone: _____ _____

Staff Last Known Address: _____

City: _____

State: _____ **Zip:** _____

Other Information:

Staff 2

First MI Last

Staff Full Name: _____ ___ _____

Staff Social Security #: _____

Staff Title: _____

Staff Date of Birth: _____ _____

Staff Home Phone: _____ _____

Staff Last Known Address: _____

City: _____

State: _____ **Zip:** _____

Other Information:

Staff 3

First MI Last

Staff Full Name: _____ ___ _____

Staff Social Security #: _____

Staff Title: _____

Staff Date of Birth: _____ _____

Staff Home Phone: _____ _____

Staff Last Known Address: _____

City: _____

State: _____ **Zip:** _____

Other Information:

Witnesses

How many Witnesses are there to this incident? _____

Witnesses 1

	First	MI	Last
Staff Full Name:	_____	___	_____

Title/Relationship: _____

Last Known Address: _____

City: _____

State: _____ **ZIP:** _____

Witness Home Phone: _____ **Witness Other Phone:** _____

Witnesses 2

	First	MI	Last
Staff Full Name:	_____	___	_____

Title/Relationship: _____

Last Known Address: _____

City: _____

State: _____ **ZIP:** _____

Witness Home Phone: _____ **Witness Other Phone:** _____

Witnesses 3

	First	MI	Last
Staff Full Name:	_____	___	_____

Title/Relationship: _____

Last Known Address: _____

City: _____

State: _____ **ZIP:** _____

Witness Home Phone: _____ **Witness Other Phone:** _____