Out of State Department of Health and Social Services Children's Residential Incident Report

Organization Information		Form Completed By	
Name		Name of Reporter	
Administrator		Title	
Address		Agency	
Telephone and Fax		Phone Number	
Contact for Incident		Signature (if faxed)	
Recipient Information		Date Form Filled Out	
Name		**Notifications**	
Medicaid Number		☐ Parent, Legal Guardian or Legal Representative	
DOB		☐ Adult Protective Services (within own state)	
Gender		☐ Behavioral Health	
Admission Date		☐ Division of Juvenile Justice	
Incident Information		☐ Probation Officer	
Date		☐ Office of Children's Services	
Time		☐ Social Worker	
Location		☐ Psychiatric Nurse	
Type of Incident (Check Box(es))		☐ Public Health Licensing Unit (in own state)	
Report Immediately (within 24 hours) Check Box		☐ Law Enforcement Agency	
☐ Death (including accidental death)		☐ Person/Agency:	
☐ Suicide (including attempt or threat) requiring an increase in observation		**Staff Involved in Incident (Name and Contact Info)**	
		Name	Contact Info
☐ Allegation of sexual Abuse			
☐ Perpetrator			
☐ Victim			
☐ Harm to self or others (requiring medical care administered by a licensed practitioner)		**Witnesses (Name & Contact Info)**	
		Name	Contact Info
☐ Use of seclusion or restraint (including emergency medications)			
☐ Elopement			
☐ Law enforcement involvement (not on TX plan)			
☐ Internal Investigations regarding AK clients			
☐ Fire or other disaster			

If unknown at admission / not identified on TX plan, the following incidents must be reported no later than first working day known:

☐ Pregnancy Estimated Due Date:

☐ Severe distress or depression

☐ Non-emergency medical care requiring parent / guardian consent.

Summary of Incident	
Describe circumstances or events leading up to incident	
Describe actions taken in response to incident	
Describe follow-up plans	
Incident Analysis	
Factors contributing to incident	
Actions necessary/taken to prevent similar future incident and person responsible for implementation	