|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **Companion Home and Alternative Living Services  Incident Report** | | | | | | | | | | |
| COMPANION HOME / ALTERNATIVE LIVING PROVIDER’S NAME | | | | | | | | DATE | | | |
| ADDRESS | | | | | | | | TELEPHONE NUMBER (AND AREA CODE) | | | |
| CLIENT’S NAME | | | | | | | | AGE | | | |
| DATE AND TIME INCIDENT OCCURRED | | | | | | | | | | | |
| **Incident Type (check all that apply)** | | | | | | | | | | | |
| **Medical** | | | **Behavioral** | | | | **Safety** | | | | |
| Injury / accident  Hospitalization  Death of a client  Illness or other condition  Medical error / refusal  Poisoning  Unknown injury  Other: | | | Assaultive behavior  Client criminal activity  Property destruction  Non-consenting sexual activity  Self-injurious behavior  Suicidal behavior  Theft / burglary  Other: | | | | Client abandonment  Suspected abuse / neglect  Financial exploitation  Fire / natural disaster  Missing client  Transportation incident  Victim of criminal activity  Other: | | | | |
| **Incident Information** | | | | | | | | | | | |
| DESCRIPTION OF INCIDENT | | | | | | | | | | | |
| DESCRIPTION OF INJURIES | | | | | | | | | | | |
| PROPERTY DAMAGE OR THEFT (WITH ESTIMATED VALUES) | | | | | | | | | | | |
| WHAT TOOK PLACE JUST PRIOR TO THE INCIDENT? | | | | | | | | | | | |
| ACTIONS TAKEN IMMEDIATELY FOLLOWING INCIDENT | | | | | | | | | | | |
| **Notifications and Methods** | | | | | | | | | | | |
| Examples: law enforcement; Adult Protective Services, DD Case Manager, guardian / family; delegating nurse. | | | | | | | | | | | |
| PERSON CONTACTED | | RELATIONSHIP | | DATE NOTIFIED | | EMAIL | | | MAIL | FAX | PHONE |
|  | |  | |  | |  | | |  |  |  |
|  | |  | |  | |  | | |  |  |  |
|  | |  | |  | |  | | |  |  |  |
|  | |  | |  | |  | | |  |  |  |
|  | |  | |  | |  | | |  |  |  |
| Was the person involved seen by a physician or taken to a hospital?  Yes  No  If yes, list name of physician and facility: | | | | | | | | | | | |
| Was First Aid administered?  Yes  No  If yes, list type of care and given by whom: | | | | | | | | | | | |
| Was the press notified or involved?  Yes  No  If yes, list names and types: | | | | | | | | | | | |
| Were law enforcement agencies contacted or involved?  Yes  No  If yes, list name(s) of responding officer(s): | | | | | | | | | | | |
| Was anyone taken into custody or arrested?  Yes  No  If yes, list name(s) and destination: | | | | | | | | | | | |
| Were neighbors or the surrounding community involved?  Yes  No  If yes, in what way: | | | | | | | | | | | |
| **Report Completed by:** | | | | | | | | | | | |
| SIGNATURE DATE | | | | | PRINTED NAME OF PERSON COMPLETING REPORT | | | | | | |