INCIDENT REPORT (SFY 2009)

Case #:

SECTION 1 – CONSUMER INFORMATION

Name of Consumer	*First:	Middle:	Last:	
Social Security #		*Gender: ☐ Male Female	*DOB	
Residence Address	*Street Address:	*City:	*Zip:	*Phone:

*Consumer Competency Level	*ADLs (Consumer Needs Assistance With) Check All That Apply
High ☐ Moderate Low	☐ Walking ☐ Wheelchair ☐ Bathing ☐ Eating ☐ Transfer ☐ Total Care X None Verbal Yes ☐ No

Diagnosis(es):

Name of Doctor & Phone #:

List Consumer's Current Medications or attach Medication Administration Record (MAR):

SECTION 2 – DESCRIPTION OF INCIDENT *(Staff person with the most direct knowledge of incident fills out this section.)*

***TYPE OF ALLEGED INCIDENT**

Reminder: Abuse, Neglect and Exploitation must be reported to APS via Fax: (505) 476-4913 or Phone (866) 654-3219

Abuse ☐ Neglect ☐ Exploitation ☐ Natural/Expected Death

☐ Unexpected Death ☐ Emergency Services ☐ Law Enforcement Involvement ☐ Environmental Hazard

Additional Incident Type for Use ONLY by Licensed Healthcare Facilities or Agencies ☐ Injuries of Unknown Origin

Person responsible for individual's care at time of incident:

If this person is employed by a provider agency, which agency:

Has this happened before? ☐ Yes No Was provider notified of incident? ☐ Yes No

Were other consumers/individuals present? ☐ Yes No If, Yes, Other Consumer's Initials:

Was anyone else present at the time of the incident: Yes ☐ No If Yes, Identify below:

Name:	Title or Relationship:	Phone
Name:	Title or Relationship:	Phone:

*Date Incident Occurred:	*Time:	*☐ AM PM ☐ Unknown

Describe what you saw and/or what you heard in order of occurrence:

***Before the Incident:**

***During the Incident:**

***After the Incident:**

Person Completing Sections 1& 2

*Confidentiality Desired: ☐ Yes No	*Name: r	*Agency: Alegria Family Services	*Title/Relationship: .	*Phone: 505-450-9050	*Date Completed:	*Time Completed

DOH FAX (800) 584-6057 e-mail: incident.management@state.nm.us
When faxing information that is not on this form please label it with consumer's name and incident date.

Name of Consumer	First:	Middle:	Last:	SSN:	Date of Incident:

SECTION 3 – AGENCY / FACILITY INFORMATION

Reporting Agency: Alegria Family Services		Incident Coordinator:		
Address: 2921 Candelaria NE # 105	City: Albuquerque	Zip:87110	County: Bernalillo	Phone:505-450-9050

SECTION 4 – ADMINISTRATIVE INFORMATION *Check the applicable box(s) below:

X DD Waiver [If DD check Jackson: ☐ YES x NO] ☐ D&E Waiver ☐ Medically Fragile Waiver ☐ DD/State General Fund

☐ ICFMR ☐ Family/Infant/Toddler ☐ TBI ☐ Diagnostic & Treatment Facility ☐ Limited Diagnostic & Treatment Facility

☐ Adult Residential Care Facility ☐ Home Health ☐ Hospice ☐ Nursing Facility ☐ Specialty Hospital ☐ Other

DD Programs ONLY: Type of residential services being received by this consumer

☐ Assisted ☐ Supported x Family Living ☐ Supervised ☐ Respite ☐ None

INITIAL ACTIONS TAKEN BY THE AGENCY/FACILITY TO ASSURE HEALTH & SAFETY:

Was law enforcement contacted? ☐ Yes No
Is the consumer still in the facility/agency? ☐ Yes No

PLANS FOR FURTHER ACTIONS IN RESPONSE TO THE INCIDENT:

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SECTION 5 – NOTIFICATIONS TO AGENCIES REQUIRED

Always notify DOH/DHI within 24 hours via FAX: (800) 584-6057
Notify Adult Protective Services/Child Protective Services to Report Abuse, Neglect, Exploitation ONLY
CPS FAX: (505) 841-6691 APS FAX: (505) 476-4913 e-mail: incident.management@state.nm.us
or Phone APS: (866) 654-3219 Name of Person Phoned:

Legal Guardian None ☐ Notified	Guardian Name & Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:		State:	Zip:
Independent Case Manager ☐ None Notified	Case Management Agency Name:			Person Making Contact:	
	Case Manager Name & Phone #:			Date:	Time:
	Street Address:	City:		State:	Zip:
Other ☐ None ☐ Notified	Name & Phone #:	Date:	Time:	Person Making Contact:	
	Street Address:	City:		State:	Zip:

Person Completing Sections 3, 4 & 5:

*Name:	*Title/Relationship:	*Phone: 505-450-9050	*Date Completed:	*Time Completed:

By typing your name below you are effectively signing this document. Your typed name is acceptable as a replacement for your written signature.
*Date:

OPTIONAL INFORMATION

(If choosing to file this page, it is due within 72 hours of initial report. This page is NOT required.)

Name of Consumer	First:	Middle:	Last:	SSN: - -	Date of Incident

SECTION 6 – ADDITIONAL INFORMATION **Information to be provided in cases of medical emergency services.**

☐YES☐NO Hospital Admission Required? If Yes/Discharge Date:

☐YES☐NO Medical Records FAXED to DHI on (Date):

☐YES☐NO Diagnosis(es) given at Emergency Intervention:

Comments:

Does this consumer have an existing medical diagnosis that may impact the reported incident?

☐ YES ☐ NO If yes, provide DX:

If this report involves abuse, neglect or exploitation & the responsible provider wishes to confirm that a person in our employ has committed the alleged event, check the appropriate box, then sign and date at the bottom of this page:

☐ Abuse ☐ Neglect ☐ Financial Exploitation

What measures have been put in place to remedy the situation and to ensure the health and safety of the consumer?

Additional Information that may be pertinent to this incident?

Authorized by:	Last Name:	First Name:	Title:	Agency:

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