DIVISION OF DEVELOPMENTAL DISABILITIES

EVENT REPORT FORM

Please print or type on all sections of the form. *Report all events listed as a Reportable Category which affect a DMH-DD Consumer*
Immediately report & submit Report Form to DD for Abuse/Neglect, Critical, and Death. All other events submit Report Form within next business day of event or discovery.

1.DMH Use Only *(optional review box, preferred to be completed on line)*
Review Date: _____ **DMH Reviewer:** _____
List Incident Type(s):

Event #

2.Was the event a Critical Incident? ☐ Yes ☐ No
Was there a report, suspicion or allegation of abuse, neglect or misuse of consumer funds/property? ☐Yes ☐No

3.State Oversight Organization:

Responsible Organization:	***Reporting* Organization Name:** *Complete only if different from Responsible Organization*
Org ID #:	**Org ID#:**

4.Event Date & Time ____/____/_____ ☐ **Check if date is estimate**
Month Day Year
____:____☐**AM** ☐**PM** ☐ **Check if time is estimate**

(Complete this section only if different than event date/time)
Discovery Date & Time ____/____/_____
Month Day Year
____:____☐**AM** ☐**PM**

5.Program Category Pertinent to Event *(Check One-DD service the individual was receiving at the time of the event.)*

☐ Case Management	☐ Group Home	☐ Personal Assistant	☐ Supported Employment	☐ Other-Community _____
☐ Day Habilitation	☐ ISL	☐ Respite	☐ Self-Directed Supports	☐ Non DMH Service

Location of Event *(Select the location/s where the event occurred.)*

☐ Bathroom	☐ Dayroom/Living Area	☐ Grounds/Yard	☐ Kitchen	☐ Training Area/Program Center
☐ Bathtub/Shower	☐ Deck/Patio	☐ Gym/Recreation Area	☐ Laundry Room	☐ Unknown
☐ Bedroom	☐ Dining Area/Cafeteria	☐ Hall	☐ Porch	☐ Utility Room
☐ Community Outing	☐ Emergency Room/Hospital	☐ Home Visit	☐ Stairs	☐ Vehicle
☐ Work/School	☐ Other narrative:			

Persons Involved

6.Status: Consumer , Staff, Other –specify in space below
Role: Alleged Perpetrator, Complainant , Informant, On Duty Non Witness, Reporter , Victim , Witness

Last Name *Print or Type*	**First Name**	**Status**	**Role**	**Individual DMH ID #**

☐ *See attached addendum.*

Notifications

7.Notified Types: 911, Agency Administrator, DFS, DHSS, DMH Facility Head, Highway Patrol, Local Law Enforcement , Nurse, Physician, Support Coordinator, Other-Specify

Notified Type	**Contact Name & Title**	**Date**	**Time**
DMH or TCM **Required Notification**			____:____☐AM ☐PM
			____:____☐AM ☐PM
			____:____☐AM ☐PM
			____:____☐AM ☐PM
			____:____☐AM ☐PM

Name of Guardian Notified	**Related Individual's Name**		
			____:____☐AM ☐PM
			____:____☐AM ☐PM
☐ *See attached addendum.*			____:____☐AM ☐PM

Event Date & Time ____/____/_____ ____:____ ☐AM ☐PM **Individual DMH ID#:** _____ **Event #**_____

Event Description

8.Print or Type - *Describe what happened, interventions used by staff & follow up action.*

Follow Up Action:

☐ *See addendum for additional description.*

9. SEE ATTACHED ADDENDUM FOR ADDITIONAL INFORMATION *(Select all that apply if the event resulted in any of the items below.)*

☐ Elopement ☐ Emergency Procedures ☐ Injuries ☐ Death Details

10.Print Name & Title	**Signature**	**Date**	**Time**
Person Completing Form			_____:_____ ☐AM ☐PM
Other/Supervisor			_____:_____ ☐AM ☐PM
Other			_____:_____ ☐AM ☐PM

Reporting Organization-representative who can be contacted if there is a question pertaining to the completed form.

Staff Name: Phone#: