

**INCIDENT REPORT (SFY 2010)**

Fields in red are required

**SECTION 1 – CONSUMER INFORMATION**

Name of Consumer	<b>First:</b>	<b>Middle:</b>	<b>Last:</b>
Social Security #	<b>Gender</b>	<b>Male</b>	<b>Female</b>
Residence Address	<b>DOB:</b>		
<b>Street Address:</b>	<b>City:</b>	<b>Zip:</b>	<b>Phone:</b>
<b>Consumer Competency Level</b>	<b>ADLs (Consumer Needs Assistance With) Check All That Apply</b>		
<b>High</b>	<b>Moderate</b>	<b>Low</b>	<b>Walking</b>
			<b>Wheelchair</b>
			<b>Bathing</b>
			<b>Eating</b>
			<b>Transfer</b>
			<b>Total Care</b>
			<b>None</b>
			<b>Verbal</b>
			<b>Yes</b>
			<b>No</b>

Diagnosis(es):

Name of Consumer's Doctor: Doctor's 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

<b>Abuse</b>	<b>Neglect</b>	<b>Exploitation</b>
<b>Natural/Expected Death</b>	<b>Unexpected Death</b>	
<b>Emergency Services</b>	<b>Law Enforcement Involvement</b>	<b>Environmental Hazard</b>

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

Name: Title: Select Title Phone:

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

Has this happenYd before? **YES** **NO** Was provider notified of incident? **YES** **NO**Were other consumers 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 Of Incident:** **Time Of Incident:** **AM** **PM** **Unknown****Location of Incident:****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**

<b>Confidentiality Desired:</b>	<b>Name:</b>	<b>Agency:</b>	<b>Title/Relationship:</b>	<b>Phone:</b>	<b>Date Completed:</b>	<b>Time Completed:</b>
<b>YES</b>	<b>NO</b>	<small>Select Agency</small>	<small>Select Title</small>			

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

### SECTION 3 – AGENCY / FACILITY INFORMATION (Fill Out This Section If Reported By An Agency/Facility)

Reporting Agency: Select Agency      Incident Coordinator: \_\_\_\_\_

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Address: \_\_\_\_\_      City: \_\_\_\_\_      State: Select Sta      Zip: \_\_\_\_\_

County: Select County      Phone: \_\_\_\_\_

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

**DD Waiver [If DD check Jackson:      YES      NO]      D&E Waiver (CoLTS)      Medically Fragile Waiver**  
**DD/State General Fund      Family/Infant/Toddler      TBI      ICF-MR (Jackson Only)**  
**Other**

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

**Supported Living      Family Living      Independent Living      None**

#### INITIAL ACTIONS TAKEN 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:

### SECTION 5 – NOTIFICATIONS TO AGENCIES REQUIRED

Always notify DOH/DHI within 24 hours via FAX: (800) 584-6057  
Or email: [incident.management@state.nm.us](mailto:incident.management@state.nm.us)

#### Notify Adult Protective Services/Child Protective Services to report Abuse, Neglect, Exploitation ONLY

CPS FAX: (505) 841-6691      APS FAX: (505) 476-4913      SCI FAXED

or Phone APS: (866) 654-3219      SCI Phoned      Name of Person Phoned: \_\_\_\_\_

Legal Guardian	Guardian Name:	Date:	Time:	Person Making Contact:
None	Street Address:	City:	State: <small>Select State</small>	Zip:      Phone:
Notified				
Independent Case Manager	Case Management Agency Name: <small>Select Agency</small>	Person Making Contact:		
None	Case Manager Name:	Date:	Time:	
Notified	Street Address:	City:	State: <small>Select S</small>	Zip:      Phone:
Other	Name:	Date:	Time:	Person Making Contact:
None				
Notified	Street Address:	City:	State: <small>Select State</small>	Zip:      Phone:

#### Person Completing Sections 3, 4 & 5:

**Name:      Title/Relationship:      Phone:      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.

**Name:** \_\_\_\_\_

.....**OPTIONAL** =B: CFA 5H=CB  
(If choosing to file this page, it is due within 72 hours of initial report. This page is NOT required.)

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

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Does this consumer have an existing medical diagnosis that may impact the reported incident?  
YES NO If yes, provide DX:

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

Abuse Neglect Exploitation

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

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Additional Information that may be pertinent to this incident?

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Authorized by:  
Last Name: First BUa Y. H]hY. 5[ YbVh

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