ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

INCIDENT REPORT

Confidential Information

- Division staff may use this form to ensure all pertinent incident information is gathered.
- Providers may use this form or write all pertinent incident information on a separate report to the Division.

NAME *(Last, First, M.I.)* _____ FOCUS ID _____

BIRTH DATE *(Month, Day, Year)* _____ FOSTER CARE ○ Yes ○ No

PROVIDER NAME AT TIME OF INCIDENT *(Qualified Vendor, Individual Independent Provider, Provider Site Name)*

_____

NAME OF INCIDENT *(Site Name, No.)* _____

LOCATION OF INCIDENT *(Street)* _____

CITY _____ STATE _____ ZIP CODE _____

DATE OF INCIDENT _____ TIME OF INCIDENT ○ AM ○ PM

STAFF/WITNESS(ES) INVOLVED #1

STAFF/WITNESS(ES) INVOLVED IN INCIDENT *(Last, First, M.I.)* _____

PHONE NUMBER _____ IMMEDIATE SUPERVISOR _____ ○ N/A

STAFF/WITNESS(ES) INVOLVED #2

STAFF/WITNESS(ES) INVOLVED IN INCIDENT *(Last, First, M.I.)* _____

PHONE NUMBER _____ IMMEDIATE SUPERVISOR _____ ○ N/A

STAFF/WITNESS(ES) RESPONSIBLE #1

STAFF/WITNESS(ES) RESPONSIBLE IN INCIDENT *(Last, First, M.I.)* _____

PHONE NUMBER _____ IMMEDIATE SUPERVISOR _____ ○ N/A

STAFF/WITNESS(ES) RESPONSIBLE #2

STAFF/WITNESS(ES) RESPONSIBLE IN INCIDENT *(Last, First, M.I.)* _____

PHONE NUMBER _____ IMMEDIATE SUPERVISOR _____ ○ N/A

DESCRIBE INCIDENT THOROUGHLY. (What happened before, during and after the incident. Include all known facts, causes of injury and emergency measures, if applicable. Write clearly, objectively and in order of occurrence, without reference to the writer's opinion.)

WHAT HAPPENED BEFORE THE INCIDENT?

See page 3 for EOE/ADA/LEP/GINA disclosures

WHAT HAPPENED DURING THE INCIDENT?

WHAT COULD HAVE PREVENTED THE INCIDENT?

NAME *(Last, First, M.I.)* _____ DATE OF INCIDENT _____

TYPE OF MEDICAL INTERVENTION (Doctor's visit, urgent care, emergency room, hospitalization)

LOCATION OF MEDICAL INTERVENTION (Site location and address)

NOTIFICATIONS

Serious incidents, as described in the Division's Policy Manual are to be reported and written as soon as possible, but no later than 24 hours after the incident.
All other incidents, as described in the Directive, must be reported to the District office by the close of the next business day following the incident.

PARENT/GUARDIAN NOTIFIED

(If Yes, name of person notified. If No, explain why) ○ Yes ○ No ○ N/A _____

NOTIFIED BY WHOM *(Last First, M.I.)* _____ DATE/TIME OF NOTIFICATION ○ AM ○ PM

SUPPORT COORDINATOR NOTIFIED

(If Yes, name of person notified. If No, explain why) ○ Yes ○ No ○ N/A _____

NOTIFIED BY WHOM *(Last First, M.I.)* _____ DATE/TIME OF NOTIFICATION ○ AM ○ PM

CHILD/ADULT PROTECTIVE SERVICES NOTIFIED

(If Yes, name of person notified. If No, explain why) ○ Yes ○ No ○ N/A _____

NOTIFIED BY WHOM *(Last First, M.I.)* _____ DATE/TIME OF NOTIFICATION ○ AM ○ PM

TRIBAL SOCIAL SERVICES NOTIFIED

(If Yes, name of person notified. If No, explain why) ○ Yes ○ No ○ N/A _____

NOTIFIED BY WHOM *(Last First, M.I.)* _____ DATE/TIME OF NOTIFICATION ○ AM ○ PM

POLICE NOTIFIED

(If Yes, name of person notified. If No, explain why) ○ Yes ○ No ○ NA _____

NOTIFIED BY WHOM *(Last First, M.I.)* _____ DATE/TIME OF NOTIFICATION ○ AM ○ PM

PRINT NAME OF PERSON COMPLETING THIS FORM _____

SIGNATURE OF PERSON COMPLETING FORM _____ DATE _____

CORRECTIVE ACTION/COMMENTS

WHAT STEPS ARE BEING TAKEN TO PREVENT THIS FROM HAPPENING AGAIN?

PRINT SUPERVISOR'S NAME _____

SIGNATURE OF SUPERVISOR _____ DATE _____