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|  | **Question** | **Response** |
| 1 | Participant Name |  |
| 2 | Facility/Program/AFL/County of Residence |  |
| 4 | Home MCO |  |
| 5 | Date and time of Incident |  |
| 7 | Date Provider learned of Incident / Under Our Care? |  |
| 9 | Licensed Residential Service being provided? |  |
| 10 | Location of Incident |  |
| 11 | Others Involved (relationship, other consumer, staff, etc.) |  |
| 12 | MCO Record # |  |
| 13 | Date of Birth |  |
| 14 | Diagnoses |  |
| 15 | Current Meds |  |
| 16 | Adjudicated Incompetent? |  |
| 17 | TBI? |  |
| 18 | Money Follows Person? |  |
| 19 | Suicidal? |  |
|  | Homicidal? |  |
| 21 | Contacted: |  |
|  | DSS(county, contact name, phone & date notified) |  |
|  | Law Enforcement (agency, contact name, phone & date notified) |  |
|  | Parent/Guardian(name, phone & date notified) |  |
|  | Clinical Home/Treatment Team(name, phone & date notified) |  |
|  | Any others(name, phone & date notified) |  |
| 22 | Person completing this form (person with most knowledge of incident) |  |
| 22 | In your own words describe what happened and why it happened. | (Write your description on the back of this form) |
| 23 | How can you prevent this from occurring again? |  |
|  | | | |

**In your own words describe what happened and why it happened:**

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**“Completed By” Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**QP Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**