PERSONAL CARE INCIDENT MANAGEMENT REPORT

Incident Date: ____/____/_____		**Time: _____am/pm**	
SECTION I – Member Information (completed by person reporting incident)			
LAST:		**FIRST:**	
ADDRESS:	**CITY**:	**STATE**:	**ZIP:**
COUNTY:	**DOB:**	**LEGAL REPRESENTATIVE:**	
SECTION II – PROVIDER INFORMATION			
PROVIDER NAME:			
PROVIDER LOCATION:			
SECTION III – DESCRIPION OF INCIDENT (completed & signed by person reporting incident)			
Describe in detail the reportable incident including other persons involved. Attach additional page(s) if necessary.			
Date the Provider Learned of the Incident: Date: _____/_____/_____ Time: _____ **Signature of Person Reporting Incident: _____ Date: _____/_____/_____**			
SECTION IV– Incident Information (completed by Agency RN or Director)			
INCIDENT TYPE: ☐ SIMPLE ☐ CRITICAL ☐ ALLEGED ABUSE, NEGLECT, EXPLOITATION			
ALLEGED INCIDENTS(S) Check all that apply:			
ABUSE:	**☐ PHYSICAL**	**☐ SEXUAL**	**☐ VERBAL** **☐ EMOTIONAL**
NEGLECT:	**☐ NUTRITIONAL**	**☐ MEDICAL**	**☐ SELF** **☐ ENVIRONMENT**
EXPLOITATION	**☐ FINANCIAL**	**☐ THEFT**	**☐ DESTRUCTION OF PROPERTY**
ACCIDENT/INJURY:	**☐ (REQUIRING TREATMENT BEYOND FIRST AID)**		
DEATH	**☐ ANTICIPATED**	**☐ UNANTICIPATED**	**☐ DATE DEATH _____**
TREATMENT ERROR:	**☐ MEDICATION**	**☐ OTHER (DESCRIBE): _____**	

SECTION V – Incident Follow-up

(completed by Agency RN; signed by Agency RN & Agency Director/Administrator); filed in administrative file)

Member's Name (as reported in Section I): _____

Provide a detailed description of incident investigation. Attach additional page(s) if necessary.

_____ _____ _____

Signature Of Investigator **Title** **Date**

INDICATE WHICH OF THE FOLLOWING AGENCIES AND/OR INDIVIDUALS HAVE BEEN INFORMED

Adult or Child Protective Services?	**☐ YES ☐ NO**	**NAME: _____ DATE: _____**
Member's Physician?	**☐ YES ☐ NO**	**NAME: _____ DATE: _____**
Police?	**☐ YES ☐ NO**	**NAME: _____ DATE: _____**

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Page 3: Describe follow-up actions taken and any systemic actions within the agency being taken to assure health and safety. Attach additional page(s) if necessary.

_____ _____

Signature of Agency Director/Administrator **Date**

_____ _____ _____

Signature of Registered Nurse (RN) **Title** **Date**