PERSONAL CARE SERVICES PROGRAM
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 – DESCRIPTION OF INCIDENT (completed & signed by person reporting incident)			
Describe in detail the reportable incident including other persons involved. Attach additional page(s) if necessary.			

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DATE THE PROVIDER LEARNED OF THE INCIDENT: DATE: TIME: _____AM/PM

SIGNATURE OF PERSON REPORTING INCIDENT_____ DATE:

SECTION IV-INCIDENT INFORMATION
(completed by the Agency RN or Director)

INCIDENT TYPE: ☐ SIMPLE ☐ CRITICAL ☐ ALLEGED ABUSE, NEGLECT, EXPLOITATION

ALLEGED INCIDENT(S) CHECK ALL THAT APPLY:

ABUSE: ☐ PHYSICAL ☐ SEXUAL ☐ VERBAL ☐ EMOTIONAL

NEGLECT: ☐ NUTRITIONAL ☐ MEDICAL ☐ SELF ☐ ENVIRONMENTAL

EXPLOITATION: ☐ FINANCIAL ☐ THEFT ☐ DESTRUCTION OF PROPERTY

ACCIDENT/INJURY: ☐ REQUIRING TREATMENT BEYOND FIRST AID

DEATH: ☐ ANTICIPATED ☐ UNANTICIPATED DATE OF DEATH:

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.

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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
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 and Title:		Date: