agency for persons with disabilities
State of Florida

INCIDENT REPORTING FORM

THIS DOCUMENT IS SUBJECT TO CONFIDENTIALITY REQUIREMENTS AND SHOULD BE HANDLED ACCORDINGLY

APD STAFF USE ONLY: **REGION:_____** **FIELD OFFICE #:_____**
REVIEWED BY:_____ **REVIEWED DATE:_____**
ADDITIONAL STAFF REVIEW: _____ **FORWARDED TO: _____**
Medical Case Manager _____ **Regional Operations Manager _____**
APD Behavior Analyst _____ **Deputy Director of Operations _____**

INITIAL REPORT: ☐ **FOLLOW-UP ONLY: ☐**

PERSONS INVOLVED	NAME	DATE OF BIRTH	SEX	PIN #	RELATIONSHIP TO APD

Date of Incident: **Time of Incident:** **County:**

☐Hotline Called ☐ Law Enforcement Involved ☐Parent/Legal Rep. Notified
☐DCF Notified (if in DCF custody) ☐ ROM/ Designee Notified ☐ WSC Notified

CRITICAL INCIDENT – Must be reported immediately

☐ Unexpected Client Death ☐ Media Involvement ☐ Missing Child/Incompetent Adult
☐ Life Threatening Injury ☐ Violent Crime Arrest
☐ Sexual Misconduct ☐ Verified Abuse Report

REPORTABLE INCIDENT – Must be reported by next business day

☐ Expected Client Death ☐ Client Injury ☐ Suicide Attempt ☐ Non-Violent Crime Arrest
☐ Altercation ☐ Missing Competent Adult ☐ Baker Act ☐ Other

INCIDENT LOCATION

☐ Licensed Home ☐ Community Based Service ☐ Supported Living ☐ Family Home ☐ ICF/DD ☐ DDDP ☐ School ☐ Other

PROVIDER INFORMATION Complete information with no abbreviations	
Name of Facility or Provider:	**Address:**
Telephone Number:	**Date of This Report:**

DESCRIPTION OF EVENT

WHO, WHAT, WHEN, WHERE, HOW, ANY INJURY OR TREATMENT PROVIDED

Click here to enter text._____

Person Reporting:_____ **Phone:_____**

Reviewing Supervisor:_____ **Phone:**

Waiver Support Coordinator: _____ **Phone: _____**

FOLLOW-UP REPORT

(This section must be filled out within 90 days)

PERSONS INVOLVED	NAME	DATE OF BIRTH	SEX	PIN #	RELATIONSHIP TO APD

Date of Initial Incident: **Date of Follow-Up Report:**

Briefly describe follow-up measures taken (Corrective, Legal, Medical, Disciplinary, or other measures) since incident was last reported (include dates if applicable):

Click here to enter text.

Immediate/Follow-up Action Taken by Region (if applicable):

Click here to enter text.

Person Reporting: _____ **Phone:**

Reviewing Supervisor: _____ **Phone:**

Waiver Support Coordinator: _____ **Phone:**

APD Only	Lead/Backup Staff on Follow-Up
	Plan of Remediation Initiated: ☐

Incident Reporting Form Instructions

Please note that all information filled out on this form must be typed, with the exception of any signatures and/or initials.

This incident Reporting Form does **not** replace the abuse, neglect and exploitation reporting required by state law and rule and must always be immediately reported to the Florida Abuse Hotline at 1-800-962-2873.

Critical Incidents must be reported to the APD Regional/ Field Office immediately upon being made aware of the incident. The initial report may be made via telephone, however, an Incident Reporting Form must be filled out and submitted no later than one business day after initial reporting.

Reportable Incidents must be reported to the APD Regional/Field Office within one business day through the completion of the Incident Reporting Form.

Action

INITIAL REPORT or FOLLOW-UP ONLY: Check the box relevant to the Incident. If this is the first report being completed for an incident, check **INITIAL REPORT**. If there is follow up information regarding an incident, check **FOLLOW-UP ONLY** and complete the second page of the report. All follow-up must be noted on the second page.

PERSONS INVOLVED: List the name of all individuals involved in the incident, their Date of Birth, Sex, iBudget Pin *(if applicable)*, and their relationship to APD *(APD Consumer, Provider Employee, APD Employee)*.

DATE OF INCIDENT: The date the incident occurred.

TIME OF INCIDENT: The time the incident occurred.

COUNTY: The County in Florida that the incident occurred.

HOTLINE CALLED: Check if the Abuse Hotline was called as a result of the incident.

LAW ENFORCEMENT INVOLVED: Check if Law Enforcement was involved in the incident. This may include law enforcement called and/or law enforcement responded to incident.

PARENT/ LEGAL REP. NOTIFIED: Check if the individual's parent or legal representative was notified.

DCF NOTIFIED (IF IN DCF CUSTODY): Check box if DCF was notified. Only notify DCF if the individual involved in the incident is in DCF custody.

ROM/ DESIGNEE NOTIFIED: Check box if this incident was reported to APD Regional Operations Manager or designee.

WSC NOTIFIED: Check box if the involved individual's Waiver Support Coordinator was notified regarding the incident.

Critical Incident

Incidents in this category must be reported to APD immediately upon becoming aware. Select the category that applies to the incident being reported.

UNEXPECTED CLIENT DEATH: The death of an individual due to an unexpected incident. Examples may include, but not limited to, trauma, stroke, drug overdose, homicides, motor vehicle accident, etc.

LIFE THREATENING INJURY: The severe injury involving a substantial risk of death, loss of or substantial impairment of body. This may also include serious illness that may be a result of Abuse, Neglect, or Exploitation. This may include but not limited to

SEXUAL MISCONDUCT: Any sexual activity, as described in s. 393.135, F.S., that occurs between client and a provider *(Regardless of consent)*, incidents of nonconsensual sexual activity between clients or any other nonconsensual sexual activity involving a client.

MEDIA INVOLVEMENT: An unusual occurrence or circumstance that **may** initiate unfavorable media attention.

VIOLENT CRIME ARREST: The arrest of a client with violent charges. Violent charges include, but not limited to, aggravated assault, assault and battery, domestic violence, homicide, manslaughter, murder, terrorism, theft/larceny, forcible rape.

VERIFIED ABUSE REPORT: A protective investigation from the Department of Children and Families (DCF) that verifies a provider or provider staff has committed an act of abuse, neglect and/ or exploitation as defined in Chapter 39 F.S. and Chapter 415 F.S., of a client. If a provider is made aware of an abuse investigation with verified findings, the provider shall submit incident report immediately.

MISSING CHILD OR ADJUDICATED INCOMPETENT ADULT: The unauthorized absence or unknown whereabouts, for more than one (1) hour, of a minor or an adult who has been adjudicated incompetent. It is at the sole discretion of the provider to report the person missing prior to the one hour to local law enforcement and APD Regional/Field office.

Reportable Incident

Incidents in this category must be reported to APD within one (1) business day upon becoming aware. Select the category that applies to the incident being reported.

EXPECTED CLIENT DEATH: A client death that is considered "natural" from long-standing progressive medical conditions or age-related conditions. This includes, but not limited to, end stage cancers, heart disease, individuals in hospice care, etc.

ALTERCATION: A physical confrontation occurring between a client and a member of the community, a client and provider, or two or more clients at the time services are being rendered and that results in law enforcement contact.

CLIENT INJURY: An Injury sustained or allegedly sustained by a client due to an accident, act of abuse, neglect or other incident occurring during the times/he is receiving services from an APD provider that requires medical attention in an urgent care center, emergency room, or physician office setting.

MISSING COMPETENT ADULT: The unauthorized absence or unknown whereabouts beyond eight hours of a legally competent adult client receiving services from an APD provider.

- If the person is known to lack capacity to make safe decisions, it is the sole discretion of the provider to report the person missing prior to the eight ours to APD and law enforcement.

SUICIDE ATTEMPT: An act which clearly reflects the physical attempt by a client to cause his or her own death.

BAKER ACT: The involuntary admission of a client of APD to a receiving facility for involuntary examination or placement, and individuals authorized to initiate a Baker Act defined within Chapter 394 F.S.

NON-VIOLENT CRIME ARREST: The arrest of a client, which occurs while a client is under the direct care of a licensed or contracted provider, or Medicaid Waiver providers as a result of a non-violent crime. E.g. drug related charges, loitering, failure to appear, etc.)

OTHER: Any event not categorized that jeopardizes a client's health, safety or welfare.

INCIDENT LOCATION: Check the location the incident occurs. There should only be one check box checked.

PROVIDER INFORMATION: The information completed in this field should be the provider information where the incident occurred. Do not use abbreviations in Name or Address, include the Area code for the phone number and complete the date of the report completed.

DESCRIPTION OF EVENT: Provide a complete narrative description of the incident. This includes, but is not limited to, persons involved, what happened, when the incident happened, where the incident happened, how the incident happened, and any treatment or actions taken immediately by provider and others involved.

PERSON REPORTING: The person filling out the Incident Reporting Form. Include direct phone number with area code.

REVIEWING SUPERVISOR: The reviewing supervisor of the person reporting, if applicable. Include direct phone number with area code.

WAIVER SUPPORT COORDINATOR: The Waiver Support Coordinator of the individual(s) involved.

Incident Reporting Form Instructions

Follow-Up Reporting Form Instructions

Please note that all information filled out on this form must be typed, with the exception of any signatures and/or initials.

This form may be completed at a later date from the initial Incident Reporting Form.

Action

PERSONS INVOLVED: Field will be auto populated. All information is the same as on the Initial Incident Reporting Form.

DATE OF INITAIAL INCIDENT: Field will be auto populated. This is the date the initial incident occurred.

DATE OF FOLLOW-UP REPORT: The date the follow up report is completed.

FIRST TEXT BOX: Describe follow-up measures taken after Initial Incident Report was complete by the provider.

SECOND TEXT BOX: For APD office use. Describe follow-up measures taken after Initial Incident Report was complete by the APD office.

REPORTING PERSON: The person filling out the Follow-Up Reporting Form. Include direct phone number with area code.

REVIEWING SUPERVISOR: The reviewing supervisor of the person reporting, if applicable. Include direct phone number with area code.

WAIVER SUPPORT COORDINATOR: The Waiver Support Coordinator of the individual(s) involved.