pennsylvania
DEPARTMENT OF HUMAN SERVICES

Incident Report

Services for Individuals with an Intellectual Disability or Autism
55 Pa. Code Chapters 2380, 2390, 6100, 6400, and 6500

Enterprise Incident Management (EIM) users should use this form only if unable to report an incident through the EIM system. The Incident Report must be entered into EIM when access to EIM can be established.

DATE OF SUBMISSION (MM/DD/YYYY):	SECTION OF INCIDENT BEING REPORTED: ☐ FIRST SECTION ☐ FIRST AND FINAL SECTION
NAME OF LEGAL ENTITY:	MPI # / EIN #:

INITIAL REPORT

TO BE SUBMITTED WITHIN 24 HOURS OR 72 HOURS OF DISCOVERY OF THE INCIDENT

INDIVIDUAL INFORMATION

INDIVIDUAL FIRST AND LAST NAME:	MCI #:	DATE OF BIRTH (MM/DD/YYYY):
ADDRESS OF THE INDIVIDUAL:		
MENTAL HEALTH AND INTELLECTUAL DISABILITY COUNTY:	FUNDING AGENCY:	
REGION:	WAIVER / PROGRAM ENROLLMENT:	

STAFF PERSON WHO DISCOVERED THE INCIDENT

ORGANIZATION NAME:	MPI # AND SERVICE LOCATION ID #:
NAME OF STAFF PERSON WHO DISCOVERED THE INCIDENT:	PHONE NUMBER:

INCIDENT CLASSIFICATION

DISCOVERY DATE AND TIME (MM/DD/YYYY):	OCCURRENCE DATE AND TIME (MM/DD/YYYY):
TYPE OF INCIDENT (PRIMARY CATEGORY):	TYPE OF INCIDENT (SECONDARY CATEGORY, IF APPLICABLE):
ASSIGNED DEPARTMENT - CERTIFIED INCIDENT INVESTIGATOR, IF APPLICABLE:	
INCIDENT REFERRED TO THE APPROPRIATE PROTECTIVE SERVICES AGENCY? ☐ YES ☐ NO	IF YES, AGENCY THE INCIDENT WAS REFERRED TO:
IF NO, PLEASE EXPLAIN:	

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INCIDENT DESCRIPTION
DESCRIBE WHAT HAPPENED PRIOR TO, DURING, AND AFTER THE INCIDENT, INCLUDING DATES, TIMES, AND ALL PEOPLE INVOLVED INCLUDING STAFF. INDICATE THE CURRENT STATUS OF THE INDIVIDUAL:

ACTIONS TAKEN TO PROTECT HEALTH, SAFETY, AND RIGHTS
DESCRIBE THE ACTIONS TAKE TO PROTECT THE HEALTH, SAFETY, AND WELL-BEING OF THE INDIVIDUAL (INCLUDE ADMINISTRATIVE, HEALTH/SAFETY, TREATMENT, AND TARGETED INDIVIDUAL ACTIONS TO ADDRESS THE INCIDENT TO DATE INCLUDING SUPPORTS OFFERED):

WAS THE INDIVIDUAL SEPARATED FROM THE PERSON WHO CAUSED THE INCIDENT?

☐ YES ☐ NO

IF NO, PLEASE EXPLAIN:

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FINAL REPORT
TO BE SUBMITTED WITHIN 30 DAYS OF DISCOVERY OF THE INCIDENT

WITNESS INFORMATION	
WITNESS (FIRST NAME AND LAST NAME):	WITNESS RELATIONSHIP TO THE INDIVIDUAL:
WITNESS (FIRST NAME AND LAST NAME):	WITNESS RELATIONSHIP TO THE INDIVIDUAL:
WITNESS (FIRST NAME AND LAST NAME):	WITNESS RELATIONSHIP TO THE INDIVIDUAL:

INFORMATION ABOUT THE PERSON WHO CAUSED THE INCIDENT (IF APPLICABLE)	
PERSON WHO CAUSED THE INCIDENT IDENTIFIER:	PERSON'S RELATIONSHIP TO THE INDIVIDUAL:

NOTIFICATION INFORMATION	
PERSON NOTIFIED (FIRST NAME AND LAST NAME):	DATE NOTIFIED (MM/DD/YYYY):
PERSON NOTIFIED (FIRST NAME AND LAST NAME):	DATE NOTIFIED (MM/DD/YYYY):
PERSON MAKING CONTACT (FIRST NAME AND LAST NAME):	

ADDITIONAL DETAIL ABOUT THE INCIDENT
PROVIDE ADDITIONAL DETAILS DISCOVERED ABOUT THE INCIDENT SINCE THE INCIDENT WAS INITIALLY REPORTED, IF APPLICABLE:

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ACTIONS TAKEN TO PROTECT HEALTH, SAFETY, AND RIGHTS
DESCRIBE THE ACTIONS THAT HAVE BEEN TAKEN TO PROTECT THE HEALTH, SAFETY, AND WELL-BEING OF THE INDIVIDUAL SINCE THE INITIAL REPORT (INCLUDING ADMINISTRATIVE, HEALTH/SAFETY, TREATMENT, AND TARGETED INDIVIDUAL ACTIONS TO ADDRESS THE INCIDENT TO DATE INCLUDING SUPPORTS OFFERED):

CORRECTIVE ACTION DESCRIPTION
DESCRIBE THE CORRECTIVE ACTION TAKEN IN RESPONSE TO THE INCIDENT AND TO PREVENT RECURRENCE (INCLUDING THE DATE COMPLETED AND THE PERSON RESPONSIBLE FOR COMPLETION):

PROVIDER INVESTIGATION
ENTER THE PRIMARY INVESTIGATORY QUESTION:
SUMMARY OF INVESTIGATOR'S FINDINGS:
INDICATE PROVIDER INVESTIGATION DETERMINATION: ☐ CONFIRMED ☐ NOT CONFIRMED ☐ INCONCLUSIVE ☐ N/A
HAS THE FAMILY/GUARDIAN BEEN NOTIFIED OF THE OUTCOME OF THE INVESTIGATION? ☐ YES ☐ NO
IF NO, PLEASE EXPLAIN: