



**CONFIDENTIAL INCIDENT REPORT**  
 State Form 51041 (R / 10-14)  
 BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES

For use in reporting all Supervised Group Living (SGL) circumstances listed in 431 IAC 1.1-3-1(b) and all circumstances listed as reportable in Bureau of Developmental Disabilities Services (BDDS) Policy and Procedures.

- INSTRUCTIONS:**
1. This is confidential information.
  2. Use additional blank pages, if required.
  3. Please number all pages.
  4. This report may be submitted by e-mail: [IncidentReports@fssa.state.in.us](mailto:IncidentReports@fssa.state.in.us) or by fax: (317) 233-2320.

SECTION I – CONSUMER INFORMATION (Subject number <input type="text"/> )		
Name (Last, first)		Social Security number
Address (number and street, city, state, and ZIP code)		
Date of birth (month, day, year)	County	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Service type: <input type="checkbox"/> Supervised Group Living (SGL) <input type="checkbox"/> Home Health Agency (HHA) <input type="checkbox"/> Habilitation / Vocational <input type="checkbox"/> Supported Living (SL) <input type="checkbox"/> Health and Hospital Corporation (HHC) <input type="checkbox"/> Living Provider-Intermediate Care Facility / Mentally Retarded (LP-ICF/MR) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Case Management <input type="checkbox"/> Self Directed Care <input type="checkbox"/> Autism Waiver <input type="checkbox"/> Aged and Disabled Waiver <input type="checkbox"/> Developmental Disabilities Waiver <input type="checkbox"/> Other Waiver		

SECTION II – ASSOCIATED PERSON (Subject number <input type="text"/> )		
Name (Last, first)		Social Security number (Optional)
Address (number and street, city, state, and ZIP code)		
Date of birth (month, day, year)	Employer	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Subject: <input type="checkbox"/> Acquaintance <input type="checkbox"/> Co-worker <input type="checkbox"/> Family-Guardian <input type="checkbox"/> Stranger <input type="checkbox"/> Residential Staff <input type="checkbox"/> Client, other <input type="checkbox"/> Employer <input type="checkbox"/> Housemate <input type="checkbox"/> Habilitation / Vocational Staff <input type="checkbox"/> Other		

SECTION III – REPORTING PERSON – REPORTING AGENCY			
Name (Last, first)		Position	Telephone number with extension (    )
Date of report (month, day, year)	Reporting agency	E-mail of reporting agency	
Individual supervising at the time of incident		Responsible supervisory provider	

SECTION IV – INCIDENT INFORMATION		
Date of incident (month, day, year)	Time of incident <input type="checkbox"/> AM <input type="checkbox"/> PM	Severity of condition? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Where incident occurred? <input type="checkbox"/> Community <input type="checkbox"/> Community Job <input type="checkbox"/> Community Habilitation <input type="checkbox"/> Family Action Council, Habilitation, Activities of Daily Living <input type="checkbox"/> Own Home <input type="checkbox"/> Family Home <input type="checkbox"/> Home Health Agency (HHA) <input type="checkbox"/> Health and Hospital Corporation (HHC) <input type="checkbox"/> Hospital <input type="checkbox"/> Self Directed Care (SDC) <input type="checkbox"/> Supervised Group Living (SGL) <input type="checkbox"/> Living Provider-Intermediate Care Facility / Mentally Retarded (LP-ICF/MR) <input type="checkbox"/> School <input type="checkbox"/> Nursing Facility (NF) <input type="checkbox"/> Workshop <input type="checkbox"/> Other (Explain): _____		

INDICATE WHICH OF THE FOLLOWING AGENCIES AND INDIVIDUALS HAVE BEEN INFORMED:		
Adult Protective Care (APC) / Child Protective Services (CPS)? <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	Residential Provider? <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	Habilitation / Vocational Provider? <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable
Legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	Name of legal guardian	Date (month, day, year)
BDDS Service Coordinator? <input type="checkbox"/> Yes	Name of BDDS Service Coordinator	Date (month, day, year)
Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	Name of Case Manager	Date (month, day, year)
Police? <input type="checkbox"/> Yes <input type="checkbox"/> Not Applicable	Date (month, day, year)	

THIS SECTION FOR BDDS CENTRAL OFFICE USE ONLY			
Date of received by BDDS (month, day, year)	Identification number	District	<input type="checkbox"/> Seven (7) day follow-up required
Indicate who completed the follow-up: <input type="checkbox"/> Residential / Habilitation / Vocational Provider <input type="checkbox"/> BDDS Service Coordinator <input type="checkbox"/> Case Manger			All Action Completed on (month, day, year)

# CONFIDENTIAL INCIDENT REPORT

Part of State Form 51041 (R / 10-14)

## BDDS INITIAL INCIDENT REPORT NARRATIVE DETAILS

Describe the incident, condition or injury (*who, what, where, how and when*) and what was observed or heard.

Describe actions taken after the incident occurred.

Date of incident (*month, day, year*)

Name of individual

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## CONFIDENTIAL BDDS INITIAL INCIDENT FOLLOW-UP REPORT DETAILS

Describe investigation into the incident or other follow-up actions taken.

Describe systemic actions being taken to assure health and safety issues.

If reported abuse, neglect, or exploitation, was the report confirmed by the entity responsible for follow-up?  Yes  No

Completed by:	Reporting agency	Date of incident ( <i>month, day, year</i> )
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Name of individual	Social Security number
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### THIS SECTION FOR BDDS CENTRAL OFFICE USE ONLY

Date of received by BDDS ( <i>month, day, year</i> )	Identification number
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