



INCIDENT REPORT

State Form 45316 (R2 / 12-14)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION (DMHA)
YOUTH HOME AND COMMUNITY-BASED WRAPAROUND SERVICES (HCBS)

INSTRUCTIONS: Please submit completed report form via secure fax (317) 233-1986.

CONFIDENTIAL

SECTION 1: PARTICIPANT INFORMATION (Subject 1)			
Identification number	Date of birth (month, day, year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	County
Last name		First name	
Address (number and street, city, state, and ZIP code)			
Primary fund source: <input type="checkbox"/> PRTF Transition Waiver <input type="checkbox"/> 1915(i) Children's Mental Health Wraparound (CMHW) Services Money Follows the Person PRTF Demo Grant (MFP-PRTF) (Do Not Complete this Form – Go to: https://DDRSprovider.fssa.IN.gov/ifur/default.aspx)			

INDICATE WHICH OF THE FOLLOWING AGENCIES AND INDIVIDUALS HAVE BEEN INFORMED.		
Check all that apply and provide:		
<input type="checkbox"/> Residential Provider	Name	Date informed (month, day, year)
<input type="checkbox"/> Legal Guardian	Name	Date informed (month, day, year)
<input type="checkbox"/> Habilitation / Vocational Provider	Name	Date informed (month, day, year)
<input type="checkbox"/> Wraparound Facilitator	Name	Date informed (month, day, year)
<input type="checkbox"/> Child Protective Services (CPS)	Name	Date informed (month, day, year)
<input type="checkbox"/> Coroner	Name	Date informed (month, day, year)
<input type="checkbox"/> Police	Name	Date informed (month, day, year)
Supervisory provider information		
Responsible supervisory provider		Individual supervising at time of incident

SECTION II: REPORTING PERSON AND REPORTING AGENCY			
Last name		First name	
Position	Telephone number ()	E-mail address	
Date report was submitted (month, day, year)	Reporting agency		

SECTION III: INCIDENT INFORMATION	
Type of incident (brief description)	
Date incident occurred (month, day, year)	Time incident started <input type="checkbox"/> AM <input type="checkbox"/> PM
Where incident occurred: <input type="checkbox"/> Home, Own <input type="checkbox"/> Home, Family <input type="checkbox"/> Hospital <input type="checkbox"/> PRTF <input type="checkbox"/> School <input type="checkbox"/> Service Location <input type="checkbox"/> Community <input type="checkbox"/> Other (explain): _____	

SECTION III: INCIDENT INFORMATION (continued)

INCIDENT INITIAL REPORT (STANDARD) - CONFIDENTIAL

As reported in Section I – Participant Information (Subject 1)

Last name of participant		First name of participant	
Participant identification number	Date of incident (month, day, year)	Time of incident <input type="checkbox"/> AM <input type="checkbox"/> PM	

NARRATIVE: DETAILS (STANDARD)

Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how, and what was heard and / or observed.

Plan to resolve (immediate and long-term):

SECTION III: INCIDENT INFORMATION (continued)

INCIDENT INITIAL REPORT (DEATH) - CONFIDENTIAL

As reported in Section I – Participant Information (Subject 1)

Is this incident regarding the death of this participant? Yes No

Last name of participant

First name of participant

Participant identification number

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

Time of incident

AM PM

NARRATIVE: DETAILS (DEATH)

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

Time of death

AM PM

Place of death:

Home, Own (*house, apartment, etc.*)

Home, Family (*family, friend, etc.*)

Foster Home

Service Location

Hospital

School

PRTF

Work

Community

Other (*explain*): _____

Circumstances immediately preceding the death, if known:

Circumstances immediately following the death or discovery of the death, if known:

Describe all life-saving measures, if any were applicable, attempted at the time of death (*i.e., CPR administered, 911 called, transported to hospital, etc.*), if known:

If no life-saving measures were taken, explain why not (*i.e., no-code status, do not resuscitate (DNR) order, etc.*), if known:

Was the death of the individual expected? Yes No

Was there a DNR status? Yes No Unknown

What is the preliminary cause of death?

Description of the event(s) surrounding this death is as follows: