

Assisted Living and Residential Care Facilities Incident Self-Report Form

Facility name: _____ Phone: (_____) _____

Address: _____

Person reporting the incident: _____

Title: _____

Incident:

Date: _____ Time: _____ am pm Date discovered: _____

Location of incident: _____

Residents involved in incident: *(Attach additional pages if necessary.)*

Name: _____ Gender: M F

Medicaid? Yes No

Relevant diagnoses: _____

Name: _____ Gender: M F

Medicaid? Yes No

Relevant diagnoses: _____

Reported Perpetrators: (Not residents) *(Attach additional pages if necessary.)*

Name: _____ Title: _____

Phone: (_____) License or certificate #: _____

Name: _____ Title: _____

Phone: (_____) License or certificate #: _____

Witnesses: *(Attach additional pages if necessary.)*

Name: _____ Relationship / Title: _____

Phone: (_____) _____

Name: _____ Relationship / Title: _____

Phone: (_____) _____

Name: _____ Relationship / Title: _____

Phone: (_____) _____

Continued on next page

(Attach additional pages to answer the questions below, if necessary.)

Describe the incident and any injury or adverse effect to the resident(s):

What immediate measures were taken to protect the resident(s)?

Has this happened before to the same resident(s) or others? Yes No If yes, describe:

Who else was contacted (such as law enforcement, ombudsman, licensing board, etc.)?

Name of person completing this report: _____ Date: _____

Facility name: _____ Date of incident: _____

APS OFFICE USE ONLY	Branch office: _____		
Date rec'd: _____	Time rec'd: _____	Rec'd by: _____	Log #: _____
Disposition: Local unit investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No Investigator's name: _____			
Response priority: <input type="checkbox"/> 2-hour <input type="checkbox"/> Next day <input type="checkbox"/> Other: _____			
