pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

*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: ☐ INITIAL REPORT ☐ INITIAL AND FINAL REPORT
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 (IF APPLICABLE):	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 (SECONARY CATEGORY), IF APPLICABLE:
ASSIGNED DEPARTMENT-CERTIFIED INCIDENT INVESTIGATOR, IF APPLICABLE:	
WAS THE INCIDENT REFERRED TO THE APPROPRIATE PROTECTIVE SERVICES AGENCY: ☐ YES ☐ NO	
IF YES, WHICH AGENCY WAS THE INCIDENT REFERRED TO:	
IF NO, PLEASE EXPLAIN:	

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 TAKEN TO PROTECT THE HEALTH AND SAFETY AND WELL-BEING OF THE INDIVIDUAL (DESCRIBE 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 SPECIFY:

INCIDENT 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

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 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:

ACTIONS TAKEN TO PROTECT HEALTH, SAFETY AND RIGHTS
DESCRIBE THE ACTIONS THAT HAVE BEEN TAKEN TO PROTECT THE HEALTH AND SAFETY AND WELL-BEING OF THE INDIVIDUAL SINCE THE INITIAL REPORT (DESCRIBE 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: