Respite Connection, Inc.

Incident Report

Major Incident ☐ **Minor Incident** ☐

Per Waiver Rules: Report needs to be completed and turned in within 24 hours of incident.

Consumer's Name: _____ Medicaid #_____ Date of Birth:_____

Date of Incident: _____ Time of Incident: _____

Exact Location of Incident: _____

Describe who was present at the time of the incident or responded after becoming aware of the incident. Only use initials for other consumers' names to maintain confidentiality. _____

Describe the incident that occurred. Please give specific details. Include any signs that could help staff recognize a similar incident in the future prior to it occurring. _____

What injury or illness occurred or could potentially occur as a result of this incident? _____

Describe what immediate action was taken in response to the incident? (who was called, any first aid given, medical assistance provided by whom, etc.) _____

Form Completed by: _____ Date Completed:_____ Staff's Signature _____

Additional Resolution or Follow-up taken by TRC Supervisory Staff: _____

Consumer's *Service Supervisor's* Signature: _____

The Respite Connection's Reviewer Signature: _____

Copies of this completed form were sent to (Major & Minor Incidents to Director, Major Incidents only to others):

Case Manager ☐ Date Sent _____ HCBS ☐ Date Sent _____ Parent/Guardian ☐ Date Sent _____ TRC Director ☐ Date Sent _____

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