**Incident Reporting Form Instructions**

Please note that all information filled out on this form must be typed, with the exception of any signatures and/or initials.

This Incident Reporting Form does **not** replace the abuse, neglect and exploitation reporting required by state law and rule. Allegations of abuse, neglect and exploitation must always be immediately reported to the Florida Abuse Hotline at 1-800-962-2873.

Critical Incidents must be reported to the APD Regional Office immediately upon being made aware of the incident. The initial report may be made via telephone, however, an Incident Reporting Form must be filled out and submitted no later than one business day after initial reporting.

Reportable Incidents must be reported to the APD Regional Office within one business day through the completion of the Incident Reporting Form.

**Initial Report or Follow-Up Only**: Check the box relevant to the Incident. If this is the first report being completed for an incident, check **INITIAL REPORT**. If there is follow up information regarding an incident, check **FOLLOW-UP ONLY** and complete the second page of the report. All follow-up must be noted on the second page.

**PERSONS INVOLVED**: List the name of all individuals involved in the incident, their Date of Birth, Sex, iBudget Pin *(if applicable)*, and their relationship to APD *(APD Consumer, Provider Employee, APD Employee)*.

**DATE OF INCIDENT**: The date the incident occurred.

**TIME OF INCIDENT**: The time the incident occurred.

**COUNTY**: The County in Florida that the incident occurred.

**HOTLINE CALLED**: Check if the Abuse Hotline was called as a result of the incident.

**LAW ENFORCEMENT INVOLVED**: Check if Law Enforcement was involved in the incident. This may include law enforcement called and/or law enforcement responded to incident.

**PARENT/ LEGAL REP. NOTIFIED**: Check if the individual’s parent or legal representative was notified.

**DCF NOTIFIED (IF IN DCF CUSTODY)**: Check box if DCF was notified. Only notify DCF if the individual involved in the incident is in DCF custody.

**ROM/ DESIGNEE NOTIFIED**: Check box if this incident was reported to APD Regional Operations Manager or designee.

**WSC NOTIFIED**: Check box if the involved individual’s Waiver Support Coordinator was notified regarding the incident.

**OPEN COURT CASE**: Check box if the involved individual has an open court case that is pending action.

**Critical Incident**

Incidents in this category must be reported to APD within 1 hour upon becoming aware. If the incident occurs between the hours of 8:00 p.m. and 8:00 a.m., the incident must be reported no later than 9:00 a.m. Select the category that applies to the incident being reported.

**UNEXPECTED CLIENT DEATH**: The death of an individual due to an unexpected incident. Examples may include, but are not limited to, trauma, stroke, drug overdose, homicides, motor vehicle accident, etc.

**LIFE THREATENING INJURY/ILLNESS**: A severe injury or illness involving a substantial risk of death, loss of or substantial impairment of body.

**SEXUAL MISCONDUCT**: Any sexual activity, as described in section 393.135 F.S., between provider and a client (regardless of consent), sexual activity involving a child, incidents of nonconsensual sexual activity between clients or any person in the community.

**MEDIA INVOLVEMENT**: An unusual occurrence or circumstance that **may** initiate unfavorable media attention.

**VIOLENT CRIME ARREST**: The arrest of a client with violent charges. Violent charges include, but are not limited to, aggravated assault, assault and battery, domestic violence, homicide, manslaughter, murder, terrorism or forcible rape.

**PROVIDER ARREST**: The arrest of a provider or a provider employee for a potentially disqualifying offense, pursuant to Section 393.0655, F.S.

**VERIFIED ABUSE REPORT**: A protective investigation from the Department of Children and Families (DCF) that verifies a provider or provider staff has committed an act of abuse, neglect and/ or exploitation of a child or vulnerable adult as defined in Chapter 39 F.S. and Chapter 415 F.S.,. When a provider is made aware that DCF has closed their investigation with verified findings, the provider shall submit an incident report to APD immediately.

**MISSING CHILD OR ADJUDICATED INCOMPETENT ADULT**: The unauthorized absence or unknown whereabouts, for more than one (1) hour, of a minor or an adult who has been adjudicated incompetent. It is at the sole discretion of the provider to report the person missing prior to the one hour to local law enforcement and APD Regional/Field office.

**Reportable Incident**

Incidents in this category must be reported to APD within one (1) business day upon becoming aware. Select the category that applies to the incident being reported.

**EXPECTED CLIENT DEATH**: A client death that is considered “natural” from long-standing progressive medical conditions or age-related conditions. This includes, but is not limited to, end stage cancers, heart disease, individuals in hospice care, etc.

**ALTERCATION**: A physical confrontation occurring between a client and a member of the community, a client and provider, or two or more clients at the time services are being rendered and that results in law enforcement contact.

**CLIENT INJURY**: An injury sustained or allegedly sustained by a client due to an accident, act of abuse, neglect or other incident occurring during the times the client is receiving services from an APD provider that requires medical attention in an urgent care center, emergency room, or physician office setting.

**MISSING COMPETENT ADULT**: The unauthorized absence or unknown whereabouts beyond eight hours of a legally competent adult client receiving services from an APD provider.

* If the person is known to lack capacity to make safe decisions, it is the sole discretion of the provider to report the person missing prior to the eight hours to APD and law enforcement.

**SUICIDE ATTEMPT**: An act which clearly reflects the physical attempt by a client to cause his or her own death.

**BAKER ACT**: The involuntary admission of a client of APD to a receiving facility for involuntary examination or placement as described within Chapter 394, F.S.

**NON-VIOLENT CRIME ARREST**: The arrest of a client, which occurs, while that client is under the direct care of a licensed or contracted provider, as a result of a non-violent crime. This includes but is not limited to drug related charges, loitering, failure to appear, etc.

**ER VISIT/ HOSPITALIZATION**: Any illness that requires a client to receive treatment at an Emergency Room, Urgent Care Center, and/or Hospital.

**INCIDENT LOCATION**: Check the location in which the incident occured. There should only be one check box checked.

**PROVIDER INFORMATION**: The information in this field should be related to the provider submitting the Incident Reporting Form. Do not use abbreviations in Name or Address fields. Include the Area code and phone number and submission date of the report.

**DESCRIPTION OF EVENT**: Provide a complete narrative description of the incident. This includes, but is not limited to, persons involved, what happened, when the incident happened, where the incident happened, how the incident happened, and any treatment or actions taken immediately by provider and others involved.

**PERSON REPORTING**: The person filling out the Incident Reporting Form. Include direct phone number with area code.

**REVIEWING SUPERVISOR**: The reviewing supervisor of the person reporting, if applicable. Include direct phone number with area code.

**WAIVER SUPPORT COORDINATOR**: The Waiver Support Coordinator of the individual(s) involved.

**Follow-Up Reporting Form Instructions**

Please note that all information filled out on this form must be typed, with the exception of any signatures and/or initials.

This form may be completed at a later date from the initial Incident Reporting Form.

**PERSONS INVOLVED**: All information is the same as on the Initial Incident Reporting Form.

**DATE OF INITIAL INCIDENT**: This is the date the initial incident occurred.

**DATE OF FOLLOW-UP REPORT**: The date the follow up report is submitted.

**FIRST TEXT BOX**: Describe follow-up measures taken by provider after Initial Incident Report was submitted by the provider.

**SECOND TEXT BOX**: For APD office use. Describe follow-up measures taken by APD after Initial Incident Report was received by the APD office.

**REPORTING PERSON**: The person filling out the Follow-Up Reporting Form. Include direct phone number with area code.

**REVIEWING SUPERVISOR**: The reviewing supervisor of the person reporting, if applicable. Include direct phone number with area code.

**WAIVER SUPPORT COORDINATOR**: The Waiver Support Coordinator of the individual(s) involved.