Incident Report Form

**Maryland Department of Human Services**

**Office of Licensing and Monitoring**

**311 W. Saratoga Street**

**Baltimore Maryland 21201**

**Office: 410-767-7377 Fax 410-333-8408**

[**olm.incidents@maryland.gov**](mailto:olm.incidents@maryland.gov)

# Program Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provider Organization Name**: | |  | | **Provider Phone #:** |  |
| **If CPA program, CPA license address:** |  | | **CPA Office Jurisdiction (county or city):** | | |
| **For CPA, Foster Home or ILP Site address**: |  | | **For CPA, Foster Home or ILP Site Jurisdiction (county or city):** | | |
| **RCC Licensed Site:** |  | | **RCC Licensed Site Jurisdiction (county or city):** | | |
| **Program Type**:  ALU (DDA)  DETP  Group Home  High Intensity Respite  ILP  Mother –Child  TFC  TFC - Medically Fragile  Therapeutic Group Home (DHMH) | | | | | |

# Incident Information

**Incident Date**: **Incident Time**:  am  pm

**Date Reported to OLM by Telephone or Email:** **Time Reported to OLM by Telephone or Email**: am  pm **Date Written Report Sent to OLM by Email or Fax:**

**Time Written Report Sent to OLM by Email or Fax:**  am  pm

|  |  |  |
| --- | --- | --- |
| **Incident Location (If different from site location):** | |  |
| **Notification Method (Check all that apply):**  Phone  Fax  Email PDF to [olm.incidents@maryland.gov](mailto:olm.incidents@maryland.gov) | | |
| **Reporter’s Name:** |  | |
| **Reporter’s Job Title:** |  | |

# Persons Involved in the Incident

## Youth in Placement (Use additional paper if needed)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name and Last Initial of**  **Youth Involved in Incident. (DO NOT Include the Youth’s Last Name)** | **DOB** | **Gender** | **Injury sustained (Y/N)** | **Placing Agency (i.e. local DSS, DJS, CFSA, DYRS, DHMH-DDA, DHMH-BHA, or other – please specify)** |
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## Staff Members / Foster Parent (Use additional paper if needed)

|  |  |  |
| --- | --- | --- |
| **Full Legal Name** | **Position (If foster parent, provide phone number)** | **Behavior Management Certified (Y/N) (For RCC staff only)** |
|  |  |  |
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|  |  |  |
|  |  |  |

## Others involved in the incident: School Staff/Probation Officers/Neighbors, etc. (Use additional paper if needed)

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Legal Name** | **Relationship to child** | **Minor Youth**  **(yes/no)** | **Contact Phone #** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Incident Type

## Choose as many as apply to the situation. Be sure that each issue identified is addressed in the narrative.

Arrest/Incarceration of Staff or Foster Parent While On Duty

Assault Of Youth Subject Of The Incident

Assault On Foster Parent/Staff

Assault On Other Youth

Automobile/Vehicular Accident

Death Of Child

Death Of Staff /Foster Parent While On Duty

Domestic or Intimate Partner Violence

Injury To Other Youth

Injury To Foster Parent/Staff

Injury To Youth Subject Of The Incident

Possible Violation Of Youth’s Rights

Property Damage

Restraint

(provide specifics in identified section below)

Sexual Assault - Perpetrator

Sexual Assault - Victim

Suspected Abuse/Neglect

(provide specifics in identified section below)

Theft - Perpetrator

Theft - Victim

**Behavioral Issues**

Arrest/Incarceration of Youth

Awol

Bullying - Perpetrator

Bullying - Victim

Fire Setting

Gang Involvement

Police Involvement

Possession Of Contraband

School Expulsion

School Refusal

School Suspension (> 3days)

Sexual Misconduct

**Mental Health/Substance Use**

Alcohol Use/Posession

Drug Use/Possession

Emergency Petition

Homicidal Attempt

Homicidal Ideation

Ingestion Of Harmful Substance

Injury To Self

Suicidal Attempt

Suicidal Ideation

**Medical/Psychiatric Events**

Emergency Hospitalization

**Medical**

**Psychiatric**

Emergency Medical Treatment

Emergency Psychiatric Evaluation

Medical Event (Significant but Non-Emergency)

Medication Error(s)

**Other**:

**Restraint**

|  |  |  |
| --- | --- | --- |
| **Name of Behavioral Intervention Protocol used:** | |  |
| **Length of Time in Restraint:** |  | |

**Reason for Restraint:** Danger to Self Danger to Others Destruction of Property

**Type of Restraint Used:** One Person Two Persons Three Persons Small Child

**Suspected Abuse/Neglect**

|  |  |  |
| --- | --- | --- |
| **Date /Time Reported to CPS:** | **Jurisidction of CPS:** | |
| **Name Of CPS Worker Taking Report:** | |  |
| **Type of Allegation:** Physical Sexual Verbal/Mental Injury Neglect | | |

# Notification Information

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Date and Time** | **Phone/Fax/Meeting/Etc.** |
| **Program Administrator / Designee** |  |  |  |
| **Assigned LDSS/Placing Agency Case worker:** |  |  |  |
| **DHS Licensing Coordinator:** |  |  |  |
| **Parent/Guardian (if appropriate):** |  |  |  |
| **Law Enforcement:**  **Police Report#**  **Police District or Precinct:** | **Badge #:** |  |  |

# Narrative Information

**Use this space to provide details of the incident. Answer the questions below to provide a detailed account of the incident being reported. Use additional paper if necessary.**

1. Describe the incident and surrounding circumstances. Include information on antecedent behaviors, specific behaviors of the youth, staff/foster parent responses. Provide facts – avoid speculation, subjectivity or personal comments.

1. Identify the actions taken by staff/foster parents to de-escalate the situation and ensure safety of all involved. Include information about staff/foster parent intervention, behavior management techniques, the involvement of law enforcement and other emergency personnel involvement and any other relevant information regarding the intervention provided.

1. Describe any follow-up, corrective action and other relevant safety measures taken, plans/subsequent interventions put in place.

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Reporter’s Signature Program Administrator/Designee’s Signature

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Reporter Printed Name Program Administrator/Designee Printed Name