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**

# 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 |
| **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)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## 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