

In-Home and Out of Home Risk Management—Client Incident Report

Client's Name: _____ Date of completion: _____
 Date of Birth: _____ Age: _____ Date incident reported: _____
 Case Name: _____ Date incident occurred: _____

Primary Program Involvement (program where the incident occurred):

Services: Traditional Foster Care ASFC Foster Care Group Home Residential (Tx) Care Residential Safety In-Home Safety Home Supported Safety IFP Family Interaction Parenting Time EM/GPS Tracker DST (Youth) Crisis Respite Escort/Transportation DST Transportation Interpretation Independent Living Other: _____

If client is involved in any of the following programs please :

Behavioral Health Services: Foster Care (level): _____ Therapy C/CTA CCAA/CFA BLC Other: _____

Type of Incident (Check all that apply, choosing only from the following):

*CRITICAL Incidents

- Death of a child/youth resulting from abuse/neglect
- Near fatality, life threatening condition or serious injury of child/youth resulting from abuse or neglect
- Suicide, or attempted suicide of a state ward or child/youth DHHS is involved with
- Death of a state ward or child/youth DHHS is working with by other means, accidental or non-accidental
- Death or non-accidental serious injury of a staff person while on the job
- Allegations or arrests of a state ward or child/youth DHHS is involved with for serious illegal/criminal activity (i.e. homicide; manslaughter; near fatality of another person; sexual assault; assault-first or second degree; aggravated or armed robbery)
- Any other event that is highly concerning, poses potential liability, or is of emerging public interest
- Any other incident designated by the Division Director of DHHS

**All CRITICAL incidents require immediate consultation with Team Leader and immediate verbal report to DHHS. Documentation shall be delivered to COI within 5 business days of incident.*

* Non-Critical Incidents

- Medical Emergency/Hospitalization Medical Psychiatric: Hospital admitted to: _____ NA
- Minor illness that does not respond to treatment
- Change in school status
- Medication Issues Unauthorized Physical Intervention
- Run away behavior
- Psychosis/Hallucinations Self Harming Behaviors/ Self Harming Ideations
- Self Harming Statements/ Self Harming Attempts Suicide Ideations/ Suicide Statements
- Suicide Attempts Homicide Ideations/ Homicide Statements/ Homicide Attempts
- Sexual Acting Out/ Exposing Self
- Verbal Aggression/ Physical Aggression/ Intimidation/ Imminent danger Police intervention
- Other: _____ (Employees contact their supervisor re: appropriateness of Incident Report)

**All incidents require review by Team Leader within 24 hours and report to COI within 5 business days*

All Incidents

Where did the incident take place? Home School Daycare Community Other: _____

Was a police report taken? Yes No

Was a police citation issued? Yes No (if yes indicate the name of the police officer below):

Name of Officer/s: _____

Date/Time Reported to DHHS: _____

Describe the incident: _____

Risk Management—Client Incident Report

To who was the incident reported? (Check all that apply and provide all of the required information)

- | | |
|--|--|
| <input type="checkbox"/> NE Executive Director Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ | <input type="checkbox"/> Contract Compliance Coordinator Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ |
| <input type="checkbox"/> Service Director Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ | <input type="checkbox"/> Program Manager (Comm. Based/Foster Care/GH) Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ |
| <input type="checkbox"/> BGH/NE Team Leader: _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ | <input type="checkbox"/> BGH/NE YFS Leader: _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ |
| <input type="checkbox"/> Police (Indicate Police Officer Name): _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ | <input type="checkbox"/> CPS Hotline (Indicate Person Spoken to): _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ |
| <input type="checkbox"/> CFS-Case manager: _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ | <input type="checkbox"/> Therapist(s): _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ |
| <input type="checkbox"/> Biological Parent/Guardian #1: _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ | <input type="checkbox"/> Biological Parent/Guardian #2: _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ |
| <input type="checkbox"/> Other (Indicate Relationship/Name): _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ | <input type="checkbox"/> Other (Indicate Relationship/Name): _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ |

Did you notify the other programs involved? Yes No—If no, why? _____

- | | |
|---|---|
| <input type="checkbox"/> Supervisor/program: _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ | <input type="checkbox"/> Supervisor/program: _____ Time of Day: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date: _____ |
|---|---|

Was a safety plan implemented? Yes No
If yes, what was it? _____

From who were the recommendations/instructions were received?

- NE Executive Director
- Contract Compliance Coordinator
- Services Director
- Program Manager (Foster Care, Community Based Services, Facility): _____
- Team Leader/Supervisor: _____
- DHHS: _____

What instructions were received (e.g. immediate steps to take, follow-up recommendations, etc.)?

Date of Next Review/Follow up Meeting: _____
To include: _____

