**Alta California Regional Center Special Incident Report**

**Please check the appropriate box below:**

Report submitted by:  Service Coordinator  Vendor  Long-Term Health Care Facility

|  |  |  |
| --- | --- | --- |
| Report Submitted by: | Title: | Phone # |
| Agency Name: | Date Notified: | Date Submitted: |

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| --- |
| **ACRC Special Incident Reporting Requirements**: Vendors or Long-Term Health Care Facilities are required to contact Service Coordinators verbally within 24-hours and **submit written reports to the SIR Desk within 48-hours after the occurrence of the special incident.** It is ACRC’s preference that all SIRS are typed and submitted to the SIR Desk e-mail at sdesk@altaregional.org. If you do not have access to e-mail you may fax it to 916 978-6619.  **Mandated Reporting Requirements:** For Suspected child abuse or neglect the mandated reporter is required to report the incident to the responsible agency immediately or as soon as practically possible by telephone and shall prepare written report within 36 hours of receiving the information concerning the incident (PC Section 11166(a)). For Suspected Abuse of Dependent Adults and Elderly the mandated reporter is required to report the incident to the responsible agency immediately or as soon as practically possible by telephone and shall submit written report within 2 working days of making the report to the responsible agency(WIC Section 15610).  **AB40 Assembly Bill**: In September 2012 the Governor of California passed the AB40 law into effect which amends Sections 15630 and 15631 and adds 15610.67 to the Welfare and Institutions Code related to elder and dependent adult abuse:  Section 2 Section 15630 of the Welfare and Institutions Code is amended to read: (A) If the suspected or alleged abuse is physical abuse, as defined in Section 15610.63 and the abuse occurred in a long-term care facility, except a state mental health hospital or a state development center, the following shall occur:   1. If the suspected abuse results in serious bodily injury, a telephone report shall be made to the local law enforcement agency immediately, and no later than within two hours of the mandated reporting observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse. 2. If the suspected abuse does not result in serious bodily injury, a telephone report shall be made to the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse. 3. When the suspected abuse is allegedly caused by a resident with a physician’s diagnosis of dementia, and there is no serious bodily injury, as reasonably determined by the mandated reporter, drawing upon his or her training or experience, the reporter shall report to the local ombudsman or law enforcement agency by telephone immediately or as soon as practicably possible, and by written report, within 24 hours. |

**Client Information:**

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| --- | --- | --- |
| Client’s Name: | Sex:  Male  Female | UCI Number: |
| Date of Birth: | Date of Incident: | Time of Incident: |

**Medical Information:**

|  |  |
| --- | --- |
| Medical Treatment Necessary:  Yes  No  If yes, give nature of treatment: | |
| Administered by: | Location Administered: |
| Follow- up Treatment, if any: | |

**Alleged Perpetrator:**

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| **If reporting Suspected Abuse, Suspected Neglect and /or Victim of a Crime:**  Vendor, employee of vendor  Employee of non-vendor  Relative/family member    Regional center client  Self  Unknown  Other individual known to client  Not Applicable |

**Location of Incident:**

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| Location of Incident:  Community Care Facility  Long-Term Facility (ICF/SNF)  Day Program  Job Site  Community Setting  Consumer’s Own Residence  School  Other: |
| Address: |

**Vendor Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Vendor at Time of Incident: | Staff Person in Charge at Time of Incident: | | Vendor Telephone #: |
| Vendor address: | | | |
| ACRC Vendor #: | | Type of Facility:  CCL  DPH  Foster Care  Facility #: | |

**Agencies Contacted:**

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| --- | --- | --- | --- |
| Agencies/Individuals Notified: | Name of Person Contacted: | Telephone Number: | Date of Contact: |
| Service Coordinator: |  |  |  |
| Community Care Licensing |  |  |  |
| Department of Public Health Service |  |  |  |
| Parent/Guardian/ Conservator |  |  |  |
| Physician/ Hospital: |  |  |  |
| Adult Protective Services |  |  |  |
| Child Protective Services |  |  |  |
| Long Term Ombudsman |  |  |  |
| Other: |  |  |  |

**Law Enforcement Information: (Please complete if Law Enforcement was contacted):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Agency Contacted: | | Officer: | | Badge #: | Telephone #: |
| Date of Contact: | Report #: | | Comments: | | |

**Residence Type:**

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| Consumer Residence:  Self/Spouse  Parent/Family  Residential (CCF/ICF/SNF)  SLS  Other:  Facility/Provider Responsible:  Name:  Address:  City/ZIP:  Phone Number: |

**Incident Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of incident: Check only boxes that apply:** | | | |
| Suspected Abuse Exploitation | Disease Outbreak | | Sexual Incident-Consumer Aggressor |
| Suspected Neglect | Choking | | Fire Setting |
| Victim of a Crime | Medication Errors | | Suicide Attempts/Threats |
| Law Enforcement Involvement | Emergency Room Visit (only) | | Media Attention |
| Missing Person-Law Enforcement notified | Hospitalization | | Transportation Incidents |
| Death | HIPAA Violation | | Other: |
| **Injuries Beyond First Aid**: (*Received treatment by a medical professional)*  Burns Requiring Medical Treatment  Medication Reaction  Bites Break the Skin  Internal Bleeding*- (which includes bruising*  *requiring medical treatment)*  Puncture Wounds | | **Serious Injury/Accident:**  Fractures  Injury Accident-Dislocation  Lacerations req. Sutures/Staples/Glue | |

**Description of Incident:**

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| --- |
| Description of Incident (Please describe the incident, including specific information leading up to the event, location, harm to client/others, persons involved in incident, who was notified when and by whom, etc.): |
| Action Taken/Planned (Include person responsible, and how incident was resolved): |
| What steps will be taken to prevent this incident from occurring again? |