RESIDENTIAL/COMMUNITY NOTIFICATION OF INCIDENT

Select **ONE** box to the right and print either the License number **OR** Certification number. If dually licensed and certified, please check the box for the facility for which the incident is being reported. Only list **ONE** number.

☐ **Residential Facility (Lic #: _____)** ☐ **Community Setting (Cert #: _____)**

a) Date of this report _____/_____/_____	b) Date of Discovery _____/_____/_____	c) Provider Generated Incident No.	
d) Provider name:		e) Provider Telephone (include area code)	
f) Name of ADAMH/CMH Board to Whom Incident was Reported		g) Provider E-Mail Address	
h) Provider Address (street, city, state, zip)			
i) Name/Title of Person to Contact Regarding Incident		j) Telephone No. if Different from Agency No. Above	

k) Incident Date _____/_____/_____

l) Incident Time (If unknown, indicate as such) _____:_____ ☐ AM ☐ PM

m) Notifications Made (select all that apply)

☐ Affiliating Agency ☐ DYS ☐ ODMH
☐ BHO ☐ Family/Guardian ☐ ODJFS
☐ ADAMH/CMH Board ☐ Local Police ☐ OLRS
☐ CSB ☐ MR/DD ☐ Other Protective Agency
☐ Court ☐ ODH ☐ Probation Officer
☐ Other _____

Client/Resident Information

n) HIPAA-Compliant Identifier (No Names)

o) Age

p) Gender ☐ Male ☐ Female

q) Race/Ethnicity

☐ A - Asian ☐ W - White
☐ B - Black/African American ☐ H - Hispanic
☐ M - Alaskan Native ☐ Unknown
☐ N - Native American/American Indian
☐ P - Native Hawaiian/Other Pacific Islander

r) Was the Client/Resident?

☐ Victim ☐ Perpetrator ☐ Other

s) Others Involved (select all the apply)

☐ Another Client/Resident ☐ Family ☐ Staff Person ☐ Unknown ☐ Other

t) If another client/resident was involved, Was an incident notification filed? ☐ Yes ☐ No

If yes, provider generated no. of other incident.

u) Was staff injured as a result of this incident?

☐ Yes ☐ No

v) Additional Information (No names, please):

z) Signature of Person Completing Form:

Date: _____/_____/_____

Please fax completed form to the Board, and ODMH at 614-387-2987 or mail to ODMH at 30 E. Broad Street, 8th Floor, Columbus, OH 43215-3430, Attention: Standards Development & Rules Administration

DMH-0484 DMH-LIC-015

w) Incident Type

☐ Abuse and Neglect by Staff - including allegations (select one)
- ☐ Physical ☐ Verbal ☐ Neglect
- ☐ Sexual ☐ Defraud ☐ Use of Force

☐ Attempted Suicide

☐ Death of or caused by Client/Resident (check all that apply)
- ☐ Living in ODMH License Residential Facility
- ☐ Suspected Homicide ☐ Suspected Suicide

☐ Serious Bodily Injury or When Medical Intervention or Hospitalization is required (select one)
- ☐ Self-Inflicted Injury ☐ Physical Assault Injury
- ☐ Accidental Injury ☐ Unknown Cause
- ☐ Restraint Related Injury
- ☐ Illness/Medical Emergency (specify on line below) Nature of Illness: _____

☐ Medications (select one)
- ☐ Error ☐ Adverse Reaction

☐ Involuntary Termination of Treatment

☐ Sexual Assault
Was a minor involved in Sexual Assault?
- ☐ Yes ☐ No

☐ Use of Force

x) In addition, residential facilities shall also report, per OAC 5122-30-16:
Occurrences Which Necessitate the Temporary Relocation of Residents and/or Require Emergency Medical Intervention

- ☐ Fire
- ☐ Disaster (e.g., flood, tornado, explosion)

y) As a result of the selected incident type (select all that apply):

1. Was restraint and/or seclusion (as defined in OAC 5122-26-16) used and/or involved?
   ☐ Yes ☐ No

   If Yes, Type:
   - ☐ Seclusion - total min. this episode: _____
   - ☐ Physical Rest. - total min. this episode: _____
   - ☐ Mechanical Rest. - total min. this episode _____
   - ☐ Involuntary Emergency Medications

2. Are criminal charges against a client/resident being pressed by staff?
   ☐ Yes ☐ No

Revised: 08/01/2006