agency for persons with disabilities
State of Florida

APD OP 3-0006

APD INCIDENT REPORTING FORM

THIS DOCUMENT IS SUBJECT TO CONFIDENTIALITY REQUIREMENTS AND SHOULD BE HANDLED ACCORDINGLY. *All incident reports must be complete in accordance with Chapter 65G-2 Florida Administrative Code (F.A.C.) and electronically mailed to the appropriate APD Regional Incident Email. Incomplete reports will be sent back to the provider for corrections.*

1. Demographics of Incident

Date of Incident:		**Date Provider Became Aware:**	
Time of Incident:	**am/pm**	**Time Provider Became Aware:**	**am/pm**
County Incident Occurred:		**Date of Initial Report:**	

2. Persons Involved

Name	Date of Birth	iConnect ID	Relationship to APD

3. Incident Location

Setting Incident Occurred	Name of Setting	Address
☐ Licensed Group Home		
☐ Supported Living		
☐ Family Home		
☐ Adult Day Training		
☐ School		
☐ Community Based Service		
☐ Other		

4. Provider Notifications

Type of Notification	Name/Title	Date/Time
☐ DCF Hotline		
☐ DCF Case Manager (if in DCF Custody)		
☐ Law Enforcement (include Agency, Officer, and report number in details)		
☐ Purple Alert Attempted		
☐ Parent/Legal Guardian Notified		
☐ WSC Notified		
☐ ROM/Designee Notified		
☐ Open Court Case (393.11/916 Forensic Cases)		

5. Incident Type

Critical *Report within 1 hour*	**Reportable** *Report within 1 day*
☐ Covered Person Arrest	☐ Altercation
☐ Covered Person Injury as a result of client	☐ Crisis Intervention Through Involuntary Commitment (Baker Act)
☐ Life Threatening Injury/Illness	☐ Crisis Intervention Through Voluntary Commitment
☐ Media Involvement	☐ ER/Hospitalization
☐ Missing Child/Incompetent Adult	☐ Expected resident/Client Death
☐ Sexual Misconduct	☐ Missing Competent Adult
☐ Suspected of Confirmed Human Trafficking	☐ Non-Violent Crime Arrest
☐ Unexpected Resident/Client Death	☐ Resident/Client Injury
☐ Unattended in Vehicle	☐ Suicide Attempt
☐ Verified Abuse Report	
☐ Violent Crime Arrest	

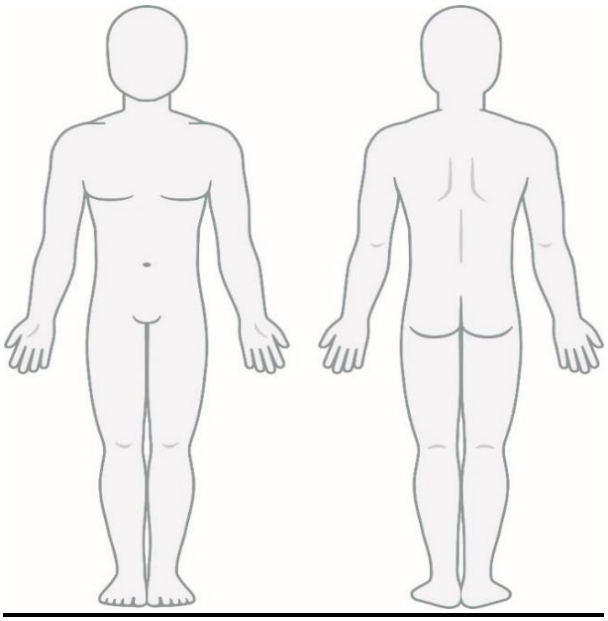
6. Incident Details

Provide all details surrounding the incident. This includes events and details prior to, during, and after the incident. Incorporate the 5 W's. (Who, What, Where, When, Why)

Click or tap here to enter text.

7. Body Diagram

Mark each area impacted during the incident.



8. Provider At Time of Incident

Name of Facility or Provider:	**Telephone**
Address:	**Email Address:**

9. Initial Reporting Provider

Name of Facility or Provider:	**Name of Reporting Person:**
Address:	**Role of Person Reporting:**
Reviewing Supervisor Name:	**Telephone Number:**
Waiver Support Coordinator:	**Telephone Number:**

10. Follow-Up Details

This section may be completed at a later date, not to exceed five business days.

Follow-Up	Date of Follow-Up
☐ 1st Follow-Up	
☐ 2nd Follow-Up	
☐ 3rd Follow-Up	

11. Provider Implemented Corrective Action Plan

12. Causes and Contributing Factors

13. Preventative Measures

14. Outline Follow-Up Actions Taken for Individual

This includes legal, medical, behavioral, therapeutic, environmental, support, equipment, or other actions.

15. Follow-Up Reporting Provider

Name of Facility or Provider:	**Name of Reporting Person:**
Address:	**Role of Person Reporting:**
Reviewing Supervisor Name:	**Telephone Number:**
Waiver Support Coordinator:	**Telephone Number:**