

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 submitted to the appropriate APD Regional Incident Email address or via the designated incident reporting system. 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
<input type="checkbox"/> Licensed Group Home		
<input type="checkbox"/> Supported Living		
<input type="checkbox"/> Family Home		
<input type="checkbox"/> Adult Day Training		
<input type="checkbox"/> School		
<input type="checkbox"/> Community Based Service		
<input type="checkbox"/> Other		

4. Provider Notifications

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

5. Incident Type

Critical <i>Initial notification within 4 hours/Report within 1 day</i>	Reportable <i>Report within 1 day</i>
<input type="checkbox"/> Covered Person Arrest	<input type="checkbox"/> Altercation
<input type="checkbox"/> Covered Person Injury as a result of client	<input type="checkbox"/> Crisis Intervention Through Involuntary Commitment (Baker Act)
<input type="checkbox"/> Life Threatening Injury/Illness	<input type="checkbox"/> Crisis Intervention Through Voluntary Commitment
<input type="checkbox"/> Media Involvement	<input type="checkbox"/> ER/Hospitalization
<input type="checkbox"/> Missing Child/Incompetent Adult	<input type="checkbox"/> Expected resident/Client Death
<input type="checkbox"/> Sexual Misconduct	<input type="checkbox"/> Missing Competent Adult
<input type="checkbox"/> Suspected of Confirmed Human Trafficking	<input type="checkbox"/> Non-Violent Crime Arrest
<input type="checkbox"/> Unexpected Resident/Client Death	<input type="checkbox"/> Resident/Client Injury
<input type="checkbox"/> Unattended in Vehicle	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Verified Abuse Report	
<input type="checkbox"/> Violent Crime Arrest	

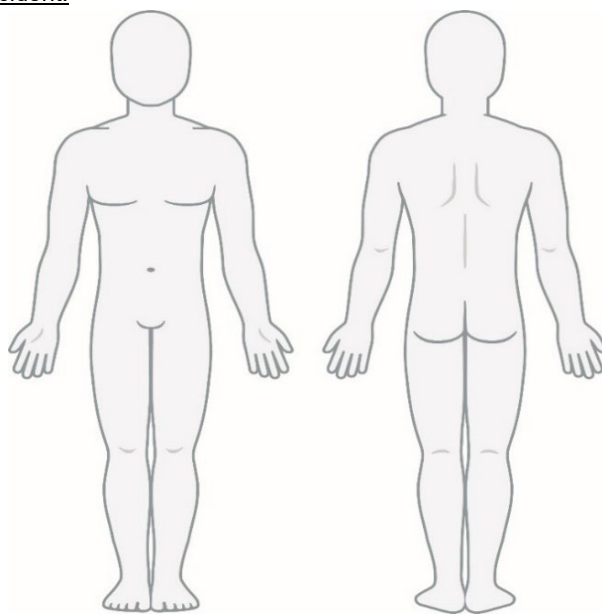
6. Incident Details

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 days.

Follow-Up	Date of Follow-Up
<input type="checkbox"/> 1 st Follow-Up	
<input type="checkbox"/> 2 nd Follow-Up	
<input type="checkbox"/> 3 rd Follow-Up	

11. Provider Implemented Corrective Action Plan

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12. Causes and Contributing Factors

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13. Preventative Measures

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14. Outline Follow-Up Actions Taken for Individual

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

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15. Follow-Up Reporting Provider

<u>Name of Facility or Provider:</u>	<u>Name of Reporting Person:</u>
<u>Address:</u>	<u>Role of Person Reporting:</u>
<u>Reviewing Supervisor Name:</u>	<u>Telephone Number:</u>
<u>Waiver Support Coordinator:</u>	<u>Telephone Number:</u>