CCS Incident Reporting Form

revised 01/17

Date of Report:	Date of Incident:	Time of Incident: am pm
Provider Name: Community Counseling Services		
Program Name:	Service:	
Report Completed By:		

Description of Incident **(if client, use client case #, not client name)**

(Factual, objective, concise: Who, What, When, Where)

If additional space is needed to describe event, attach additional sheets of paper.

At this time, medical care/treatment has been offered, but I refuse.
(if applicable)

Signature: ____ Date: ___________________________

Consequences/Follow Up Actions:

Witnesses ***(if client, list case number)*****:**

Possible Contributing Factors:

Person(s) Involved In Incident (***if client, list case number*****):**	Is this person on the ID/DD Waiver? □ **Yes** □ **No**

Any and all authoritative bodies to which this incident has been reported and the dates of those reports.

- ◻ DMH to whom: ________________________________ date contacted: ______________
- ◻ DHS to whom: ________________________________ date contacted: ______________
- ◻ Law Enforcement to whom: ________________________________ date contacted: ______________
- ◻ Other: ________________________ to whom: ________________________________ date contacted: ______________

Has a Report of Incident been made within the agency (CCS)? ◻ Yes ◻ No

If yes, indicate to whom within CCS has the Report of Incident been made?

Name: ____ Position: ____________________________ Date: ___________

Name: ____ Position: ____________________________ Date: ___________

Name: ____ Position: ____________________________ Date: ___________

Name: ____ Position: ____________________________ Date: ___________

*Complete, **written** incident report must be submitted to immediate supervisor by the end of the work day.*

DO NOT WRITE BELOW THIS LINE

Agency/Employee Related Incidents (Check All That Apply)

◻ contraband	◻ employee injury	◻ abuse report
◻ property damage	◻ theft	◻ staff threatened
◻ vehicle accident/damage	◻ visitor related concern/issue	◻ misconduct of IRS
◻ other (describe below in narrative)	◻ non-serious client related: ____	

Serious Incidents (Check All That Apply)

Involves a client and occurred on CCS property or at a CCS related event

Must be reported to DMH verbally within 24 hours

◻ **SU** Suicide (Attempt or Completed)	◻ **EMG** Emergency Room Treatment	◻ **SR** Seclusion/Restraint
◻ **ACL** Absence from Community Living	◻ **ABN** Abuse/Neglect	◻ **WKV** Workplace Violence
◻ **ELP** Elopement	◻ **DIS** Disaster	◻ **MED** Medication Error
◻ **INJ** Injury	◻ **EVC** Evacuation	◻ **DE** Death* Must be reported to DMH within 8 hrs
◻ **OTH** Other (describe below in narrative)		

Routing Procedures

Immediate Supervisor: ____ **Date:** ___________________

County Administrator (if applicable): ____ **Date:** ___________________

CCS Officer: ____ **Date:** ___________________

Executive Director: ____ **Date:** ___________________
(serious incidents only)

At the time of this report, is the Agency conducting an Internal Investigation? ◻ **Yes** ◻ **No**

If yes, is the Agency's Investigation Active or Closed? **Is this a high visibility Incident?** ◻ **Yes** ◻ **No**

Recommendations: ____

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