Stark County Board of Developmental Disabilities The Department of Contract and Investigative Services

SCBDD MUI or UI Incident Report Form

Please Print

Reporting hotline (330) 477-4477 MUI fax num	ber (330) 477-0016 E-mail MUIreport@StarkDD.org							
Provider (agency name)	Address							
Phone number Date incident discovered								
Client name	Address							
City State Zip								
Date of birth Social Security number								
SSA Assigned $\underbrace{\hspace{1cm}}_{Yes} \underbrace{\hspace{1cm}}_{No}$	SSA name							
Individual is own guardian $\underbrace{\qquad}_{Yes}$ $\underbrace{\qquad}_{No}$ Guardian appointed? $\underbrace{\qquad}_{Yes}$	Guardian name							
Phone no. Guardian address	City State Zip							
Date incident occurred (M/D/Y)	Time of incident							
Where did incident occur?	County							
Explain incident (who ,what, when, where) add additional sheet(s) as necessary								
Did injury occur? Yes No Hospital ER only Admit Describe the injury (tree to set to								
Describe the injury/treatment								
Location <i>on the body</i> where injury occurred	Individual assessed for injury? Yes No							
By whom? Title	Date							
How? Emerger	ncy transport? By whom?							
Does individual have a behavior support plan?	Does it include physical restraint?							
Were there witnesses to this incident? $\frac{1}{Yes}$ $\frac{N_0}{N_0}$	Yes No							
1 Name Title	Phone Number							
2 Name Title	Phone Number							
3 Name Title	Phone Number							

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Name	Client name						
Phone Worksite County Board employee?	Who is the primary person involved? (alleged perpetr	rator)					
Describe immediate action taken to ensure health and safety of the individual Further medical follow-up necessary? Purther medical follow-up nec							
Further medical follow-up necessary?	Phone Worksit	te		Count	y Board employee?	Yes No	
Further medical follow-up necessary?							
Who did you notify of the incident? 1 County Board verbal notification date	Describe <i>immediate action</i> taken to ensure health and	l safety of the	e individual				
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Who did you notify of the incident? 1 County Board verbal notification date	Further medical follow-up necessary?	Vac No					
1 County Board verbal notification date		ies ivo					
1 County Board verbal notification date	Who did you notify of the incident?						
2 County Board written notification date	· · · · · · · · · · · · · · · · · · ·	Yes No	4		Time		PM
3 Guardian	2 County Board written notification date		7		Time		
SSA	3 Guardian	Yes No	Date		Time	AM	РМ
S Law enforcement Ves No Date	4 SSA	Yes No	7		Time	AM	PM
What jurisdiction? 6 Child Protective Services		Yes No	→			AM	PM
6 Child Protective Services	5 Law enforcement	Yes No	Date		Time	AM	PM
*If death occurred			-				
*Signature of reporter or person completing this report Signature of reporter or person completing this report *Signature of MUI designee Signature of MUI designee Signature *Signature of MUI designee Signature *Itile Date Time AM PM AM PM PM AM P	6 Child Protective Services	Yes No	Date		Time		PM
*If death occurred	7 Other Who?	Yes No	Date		Time	AM	PM
At what location? Was the coroner notified? Law enforcement involved? *Signature of reporter or person completing this report Signature Box to be completed by Provider or County Board MUI designee Administrative action taken following incident *Signature of MUI designee Signature Title Date Title Date Title Date Tracking Log? Initials (person logging) UI Closed Date							
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Was the coroner notified? Law enforcement involved? Page 1 Date Time AM PM AM PM AM PM Date Time Date Time AM PM PM Date Time Date Date Time Date Date Time Date Date Date Date Date Date Date Dat	At what location?	14/1	ı			TIVI	1 1/1
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*Signature of reporter or person completing this report Signature		Yes No	<u></u>		Time	AM	PM
Signature Title Date	Law enforcement involved?	Yes No	Date		Time	AM	PM
Signature Title Date	*Signature of reporter or person completing this report	t					
*Signature of MUI designee Signature Tracking Log? Initials (person logging) UI Closed Date #UI designee UI Closed Date UI Closed Date			Title		Date		
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