Incident Information			
INCIDENT DATE	INCIDENT START TIME	INCIDENT END TIME	PROVIDER NAME

Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Incident Report to DDA

Persons Involved (Per your agency policy, you may use full names or initials for other involved clients.)			
LAST NAME	FIRST NAME	INCIDENT ROLE (Choose one: perpetrator, victim, witness, or unknown)	PERSON TYPE (Choose one: advocate, client, DDA State employee, LTC client, non-staff, parent / legal rep, relative, residential provider staff, vocational / day program provider staff, other staff, unknown DDA client, or unknown)
1.			
2.			
3.			
4.			
5.			
6.			

Incident Details

ANTECEDENT (WHAT HAPPENED BEFORE / LEADING UP TO THE INCIDENT)

INCIDENT DESCRIPTION

STAFF RESPONSE (WHAT DID STAFF DO IMMEDIATELY FOLLOWING / AS A RESULT OF THE INCIDENT)

AS A RESULT OF THE INCIDENT, CHECK ACTIONS TAKEN / PLANNED WITHIN NEXT SEVEN (7) DAYS.

- ☐ Client relocation
- ☐ CSCP updated
- ☐ Doctor / Nurse / Pharmacy contacted
- ☐ FA / PBSP written / updated
- ☐ Hospital admission
- ☐ IISP updated
- ☐ Increased supervision
- ☐ Medical assessment / treatment
- ☐ Mental health facility admission
- ☐ Mental health referral
- ☐ Provider initiating investigation
- ☐ Staff reassigned
- ☐ Staff reassigned – no client contact
- ☐ Staff terminated
- ☐ Staff voluntarily resigned
- ☐ Other staff action:

DESCRIBE HEALTH AND WELFARE ACTIONS TAKEN OR PLANNED AS RESULT OF INCIDENT

Were there any client injuries that required treatment beyond First Aid? ☐ Yes ☐ No

Describe any injuries as a result of this incident, who was injured, and type and location of injury:

Is abuse, neglect, personal or financial exploitation, abandonment, or improper restraint suspected? ☐ Yes ☐ No
If yes, explain briefly below.

Notifications by Provider

	DATE NOTIFIED	PERSON / ENTITY NOTIFIED	CONFIRMATION / CASE NUMBER
☐ DDA notification as required by DDA policy			
☐ Medical professional			
☐ Guardian / Legal Representative			
☐ CRU / RCS / APS / CPS			
☐ Law enforcement			
☐ Department of Health			
☐ Emergency medical / fire			
☐ Coroner / Medical Examiner			
☐ County Staff			
☐ Other			

Person Submitting Report

NAME	TITLE	DATE SUBMITTED