

INCIDENT REPORT (UI/MUI)

Clinton County Board of DD

All Providers must maintain UI logs and submit them to the Clinton County SSA Division for review, per rule
Phone: (937) 382-7889, Fax: (937) 382-0350, After Hours: (937) 725-5074, & Website: co.clinton.oh.us/boardofdd/

Individual: _____ Address: _____

Incident Date: _____ Time: _____ AM PM Location: _____

List witnesses involved (use initials for other individuals served): _____

Describe incident (who, what, where, when, how long- attach additional pages if necessary): _____

What was the Individual doing immediately before (i.e. contributing factors)? _____

Immediate Action to ensure H&W: _____

Further Medical Follow-up/Administrative Comments: _____

*Immediate to 4 hour reporting required for all allegations of Abuse/Neglect/Peer to Peer Acts/Exploitation/Misappropriation/
Suspicious/Accidental Death/Media Inquiries regarding an MUI

*The Provider of service at time of incident must complete same-day notification to Individual's residence (except to alleged PPI)

| Type of Notification | Name/Title | Date/Time |
|-------------------------------------------------------------------------|------------|-----------|
| Guardian /Advocate | | |
| County Board | | |
| Licensed or Certified Provider | | |
| Staff or Family living at Individual's home | | |
| Law Enforcement (name, badge number, jurisdiction, contact information) | | |
| CPSA (Name and contact information required for Children Services) | | |
| Support Broker (If applicable) | | |

Reporter Signature & Title: _____ Date: _____

Administrative Comments: _____

Site Supervisor/Manager _____ Date _____

Administrator/Director _____ Date _____

Injury Report

| | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------|--------------------------------------|----------------------------------|-------------------------------------|----------------------------------------|------------------------------------|-----------------------------------|--|--------------------------------------|
| <p>Type of Injury</p> <p><input type="checkbox"/> Bruise</p> <p><input type="checkbox"/> Bite</p> <p><input type="checkbox"/> Laceration</p> <p><input type="checkbox"/> Scratch</p> <p><input type="checkbox"/> Swelling</p> | <p>Body Parts Injured</p> <table> <tr> <td><input type="checkbox"/> Head/Face</td> <td><input type="checkbox"/> Neck/Chest</td> </tr> <tr> <td><input type="checkbox"/> Mouth/Teeth</td> <td><input type="checkbox"/> Abdomen</td> </tr> <tr> <td><input type="checkbox"/> Hands/Arms</td> <td><input type="checkbox"/> Back/Buttocks</td> </tr> <tr> <td><input type="checkbox"/> Feet/Legs</td> <td><input type="checkbox"/> Genitals</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> </tr> </table> | <input type="checkbox"/> Head/Face | <input type="checkbox"/> Neck/Chest | <input type="checkbox"/> Mouth/Teeth | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Hands/Arms | <input type="checkbox"/> Back/Buttocks | <input type="checkbox"/> Feet/Legs | <input type="checkbox"/> Genitals | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Head/Face | <input type="checkbox"/> Neck/Chest | | | | | | | | | | |
| <input type="checkbox"/> Mouth/Teeth | <input type="checkbox"/> Abdomen | | | | | | | | | | |
| <input type="checkbox"/> Hands/Arms | <input type="checkbox"/> Back/Buttocks | | | | | | | | | | |
| <input type="checkbox"/> Feet/Legs | <input type="checkbox"/> Genitals | | | | | | | | | | |
| | <input type="checkbox"/> Other _____ | | | | | | | | | | |

Mark location of injury



SSA REVIEW

| | | |
|-----------------------------------------|-------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Illness | <input type="checkbox"/> Rights Violation (no risk) |
| <input type="checkbox"/> Bruises | <input type="checkbox"/> Medication Error (w/o likely risk) | <input type="checkbox"/> Safety Issue |
| <input type="checkbox"/> Dental Injury | <input type="checkbox"/> Minor Injury | <input type="checkbox"/> Unknown Injury |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Overnight Relocation | <input type="checkbox"/> Unapproved Beh. Support (no risk) |
| <input type="checkbox"/> Health Concern | <input type="checkbox"/> Peer to Peer Act | <input type="checkbox"/> *Non-Incident (explain below)* |

SSA Comments: _____

SSA Signature: _____ **Date:** _____

Administrative Comments: _____

SSA Manager & Date

SSA Director & Date

Superintendent & Date

MUI

MUI # _____

| | | |
|---------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Alleged Abuse (P/V/S) | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Prohibited Sexual Relations |
| <input type="checkbox"/> Alleged Neglect | <input type="checkbox"/> Medical Emergency | <input type="checkbox"/> Rights Code Violation |
| <input type="checkbox"/> Attempted Suicide | <input type="checkbox"/> Misappropriation | <input type="checkbox"/> Significant Injury |
| <input type="checkbox"/> Accidental or Suspicious Death | <input type="checkbox"/> Missing Individual | <input type="checkbox"/> Unapproved Behavior Support (risk to health/welfare) |
| <input type="checkbox"/> Exploitation | <input type="checkbox"/> Peer to Peer Act (P/V/S/Exploit/Theft) | <input type="checkbox"/> Unscheduled Hospitalization |
| <input type="checkbox"/> Failure to Report | <input type="checkbox"/> Death other than accidental or suspicious | <input type="checkbox"/> Media Inquiries regarding an MUI |

Name of Alleged PPI: _____