

Initial UIR Form Instruction Sheet

Note: *The UIR should be typed and filled out completely.*

Please ignore the grey boxes at the top of the first page. They will be completed by the UIR Coordinator in the Regional Office.

Supervising Entity (e.g. agency, sponsor, family):

Please record name of entity who was supervising the service recipient at the time of the alleged incident.

Address of Incident:

Record the exact location where the incident occurred. Include street, city, zip code. If location is unknown, write "unknown".

Program VID#:

The site-specific code assigned at the time of program development and referred to in correspondence by the Office of Licensing. For service recipients residing at home, include their MIS #.

Program telephone number:

Telephone number of supervising entity

Program type:

OH Own Home
 SLP Supported Living Program
 SBH Boarding Home
 SNF Skilled Nursing Facility
 SA Supervised Apartment
 GH Group Home
 UA Unsupervised Apartment
 CCR Community Care Residence (Skill Provider)
 Other Other arrangement not listed above i.e. Challenge Grant, Self-Determination, Psychiatric Hospital...
 POC Purchase of Care
 ATC Adult Training Center

Type of incident:

Incident description from Incident Code Grid/A.O. 2:05.
 E.g. Assault, Physical Moderate Injury

Code:

Type Code e.g. AS114

Media interest:

Please check this field if you think this incident is or might attract media interest. Refers to media (TV, radio) or journalistic (newspaper, magazine/book) attention that has been or is likely to be generated or intensified regarding any reportable incident involving the Department Divisions, and their service recipients or employees.

Date Incident Occurred:

This is the actual date the alleged incident occurred. This is not a field for the date of discovery.

Time:

Please record actual time alleged incident occurred and AM or PM. This is not the field to record time of discovery.

Date Known to Staff:

This field is for the date of discovery by staff or sponsor.

Time:

This field is for the time of discovery by staff or sponsor.

Prepared by:

Please complete the full name of individual writing this incident report. No signatures, please.

Title:

Include title of individual writing this incident report and name of agency.

Agency:

Enter the name of the agency for which the person who prepared the UIR works for.

Date:

Record date this incident report is completed

Time:

Record time, including AM/PM, this incident report is completed

Telephone #:

Phone number of individual completing this report

Supervisor's Name:

Indicate the full name of the supervisor of the individual completing this incident report

Title:

Include title of the supervisor of the individual completing this incident report

Description of the Incident: (Who, What, When, Where and How it occurred):

Provide a concise but complete summary that explains what happened. Please be specific. Do not use abbreviations or initials.

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**People Involved.**

**[ENTER INFORMATION ON ALL AVs AND APs INVOLVED IN THE INCIDENT]**

**Role:**

**AV:** Alleged Victim

**AP:** Alleged Perpetrator

**Person Type:**

**SR:** Service Recipient

**Staff:** Staff of Agency/Sponsor

**Visitor/Other:** Family member, other

**Name:**

Fill in complete name. Avoid nicknames.

**Sex:**

Male or Female

**Residential Information:**

**Residential Name:** Agency, Own Home, Sponsor name

**Address:** Complete address including street address, city, state and zip code

**Telephone number:** Include area code

**Residential Program VID #:**

The site-specific code assigned at the time of program development and referred to in correspondence by the Office of Licensing.

**MIS #:**

Service recipient's identification number

**D.O.B.:**

Service Recipient's date of birth

**Guardian Name:**

Full name of Guardian of Service Recipient

**Guardian Address:**

Full address of Guardian including street address, city, state and zip code

**Guardian telephone number:**

Include Area Code

**Support Coordination Agency:**

Full name of Agency assigned to the Service Recipient

**Support Coordinator:**

Full name of Support Coordinator assigned to the Service Recipient

**County Medicaid No:**

Service Recipient's County Medicaid number if he/she has County Medicaid

**CCW Medicaid Number:**

Service Recipient's Community Care Waiver number if he/she is eligible for CCW

**This person is not on Medicaid:**

Check box if the Service Recipient does not have Medicaid

**DDD Case Manager:**

Full name of DDD Case Manager for Service Recipient

**Describe injuries from the Incident:**

**Injury Type:**

Describe injury. For example: bruise, laceration, fracture

**Body Part:**

Indicate which body part was injured as a result of this incident.

**Injury Level:**

Indicate Minor, Moderate or Major Injury. Refer to A.O. 2:05, pgs 13-14, for descriptions of each.

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Witnesses:

Please complete full name and title of individuals who witnessed the alleged incident. Do not include witnesses of discovery of incident.

Notifications:

Include Title, Full name, Date contacted and Time contacted. If you do not speak to the person, indicated “message left”.

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**Actions Taken or Planned:**

Please be specific in defining actions. Include dates of follow-up appointments or meetings, if applicable.

**Status:**

Please indicate pending or closed per Incident Code Grid/A.O. 2:05. Subject to DDD review.

**Finding:**

If incident is submitted closed, please indicate finding as substantiated, unsubstantiated or unfounded. Subject to DDD review and approval.

**Date Closed:**

Please complete date unusual incident report is closed. Subject to DDD review and approval. Note: although closed, DDD may still request documentation of actions pending completion.