VERMONT

Vermont Department of Disabilities, Aging & Independent Living

Critical Incident Reporting Form

Designated Agency or Specialized Services Agency Report

The Department of Disabilities Aging & Independent Living (DAIL) is to be notified of any significant event that occurs in a Designated/Specialized Services Agency. For incidents of Untimely or Suspicious Death or Mission Person, a verbal report will be made within 24 hours from the agency's knowledge of the incident to the DAIL 24-hour CIR Line, **802-241-2678**. Reports of Potential Media Involvement need to be made directly to the Developmental Disabilities Services Division (DDSD) Director/Adult Services Director (ASD) Quality & Provider Relations Director upon the Agency becoming aware of the incident.

This report form must be completed for all types of critical incidents and be submitted to DDSD/ASD within 2 business days from the agency's knowledge of the incident.

The form must be submitted by fax: **DDSD at 802 241-0410** **ASD at 802-241-0385**

Name of Individual involved:	**Date of Incident:**
Date of Birth:	**Time:**
Agency Name:	**Date Agency Became Aware of Incident:**
Program (check all that apply): ☐ DS ☐ TBI ☐ MFP ☐ AFC	**Location:**

Type of incident:

☐ Death: ☐ Untimely/Suspicious ☐ Natural	☐ Missing Person
☐ Potential Media Involvement	☐ Report of Abuse, Neglect, Exploitation/ Use of a Prohibited Practice
☐ Criminal Activity/Incarceration	☐ Medical Emergency
☐ Seclusion Restraint: ☐ Mechanical ☐ Physical ☐ Chemical	☐ Other (Includes Action by Paid Staff/Provider/Worker paid by DAIL funds:
☐ Suicide Attempt	

Persons who witnessed or were involved in the incident:

Description of incident: (What happened before, during and after the incident; identify precipitants, interventions used by staff to attempt to prevent/manage the incident, and description of behaviors observed during the incident):

Action(s) taken as a result of the incident:

Describe any planned follow up in response to the incident:

Persons and agencies notified: (Include when and how notified. If an agency, name of staff to whom report given)

Reporter's Name/Signature: **Date:**
Phone Number: (REQUIRED)

Supervisor review of Incident/comments: (QDDP for DDSD) (CM/SC for MFP/AFC)

Supervisor's Name/Signature: **Date:**