

**Delaware County Board of Developmental Disabilities
Incident Reporting Form (IRF)**

Please Print

Name of eligible individual _____

Who is the primary person involved? (alleged perpetrator) - leave blank if it is another eligible individual - call IA to give name

Name _____ Address _____

Phone _____ Worksite _____ County Board employee? Yes No

Describe **immediate action** taken to ensure health and safety of the individual _____

Further medical follow-up necessary? Explain _____

Notifications MUST be made prior to submitting IRF to the Investigative Agent

Verbal notification to IA/on-call SA (after hours) Date _____ Time _____ by _____
**4 hour verbal notification is required if reporting abuse, neglect, misappropriation, exploitation, suspicious/accidental death, media inquiries regarding MUIs

Written notification to IA/SA/EI Specialist Date _____ Time _____ by _____
**due by 3pm the next business day following the date of discovery for all MUIs

Legal guardian Date _____ via _____ by _____
**verbal notification is required on the date the incident was discovered for MUIs - not required to be in written form

Personal Advocate Date _____ via _____ by _____
** verbal notification is required on the date the incident was discovered for MUIs - not required to be in written form

Licensed or certified residential provider Date _____ via _____ by _____
**verbal notification is required on the date the incident was discovered for MUIs - not required to be in written form

Support Administrator/EI Specialist Date _____ via _____ by _____
**verbal notification is required on the date the incident was discovered for MUIs - written due by 3pm next day

Law enforcement Date _____ via _____ by _____
**immediate notification is required for abuse, including misappropriation, or neglect, which may constitute a criminal act
What jurisdiction? _____

Children's Protective Services Date _____ via _____ by _____
**immediate notification is required for allegations of abuse or neglect of an individual under the age of 21

Other? Who? _____ Date _____ via _____ by _____

Name of person completing this report _____

Signature _____ Date _____

This box is to be completed by a Provider Administrator

Administrative action taken following incident _____

Signature of Provider Administrator _____ Date _____

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