PARTICIPANT CRITICAL INCIDENT REPORT
Policy- GA-5A
TO BE COMPLETED BY PROGRAM MANAGER

Program/Site Name: Click or tap here to enter text.

Child Name: Click or tap here to enter text. D.O.B. Click or tap here to enter text. Sex: ☐ M ☐ F

Incident Occurrence Date: Click or tap to enter a date. Time: ☐ AM ☐ PM

Program Notification Date: Click or tap to enter a date. Time: ☐ AM ☐ PM

Name of Staff Incident Reported to: Click or tap here to enter text. Title: Click or tap here to enter text.

Contract Manager Notification Date: Click or tap to enter a date. ☐ Oral ☐ Written

Today's Date: Click or tap to enter a date.

PARTICIPANT INFORMATION

Identification Number: Click or tap here to enter text.

Relationship to Child: Click or tap here to enter text.

Service Level: ☐ Level 1P ☐ Level 2P ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4
☐ Level CO ☐ Level TO ☐ Level TR

STAFF

Family Support Specialist Name: Click or tap here to enter text.

Supervisor Name: Click or tap here to enter text.

Type of Incident *(please check all that apply):*
☐ household members death ☐ critical injury ☐ serious abuse
☐ litigation pertaining to a particular participant ☐ participant threat against a staff member
☐ other *(which would include any information regarding a non-participant that would warrant a report)*

Description of the incident: Give a brief summary here and attach a detailed narrative if necessary. Specific information to include: Description of Incident- Include the following information, if applicable:

1. Names of individuals involved in incident. Click or tap here to enter text.
2. Details leading up to the incident. Click or tap here to enter text.

3. Brief family history. Click or tap here to enter text.
4. Service history (number of visits, referrals made). Click or tap here to enter text.
5. Criminal charges/reports to Statewide Central Registry, if any. Click or tap here to enter text.

Describe Action Taken- Include the following information, if applicable:

1. Authorities notified, such as Child Abuse Hotline, police, Child Protective Services/Administration of Childrens Services. Click or tap here to enter text.
2. Name and location of hospital, as well as cause of death (if known), diagnosis of illness or injury. Click or tap here to enter text.
3. Notification of lead agency Director, OCFS Contract Manager, or any other pertinent parties. Click or tap here to enter text.
4. Referrals/services provided to family since the incident (required for participant/family death).
   ☐ No ☐ Yes
   A. If yes, what services?
   B. If no, explain why. Click or tap here to enter text.
5. Referrals/services provided to staff since the incident. (required for participant/family death).
   ☐ No ☐ Yes
   A. If yes, what services?
   B. If no, explain why. Click or tap here to enter text.

Statewide Central Register Reporting-

Was this incident reported to the NY Statewide Central Register *(if applicable)*? ☐ No ☐ Yes

If yes, register call ID number: Click or tap here to enter text.

If no, please explain: Click or tap here to enter text.

If open case with CPS/ACS, is a consent to speak to the worker signed? ☐ No ☐ Yes

FOR OCFS USE ONLY

Date initial notification received: Click or tap to enter a date.

VIA ☐ Email ☐ Voicemail ☐ Phone Call ☐ In-Person

By: Click or tap here to enter text. To: Click or tap here to enter text.

Date form received: Click or tap to enter a date. Initials: Click or tap to enter a date.

Litigation ☐ No ☐ Yes Media Coverage: ☐ State ☐ Local ☐ National ☐ N/A

HFA Notification Date: Click or tap to enter a date.

Updates since initial report: