



Complaint and Incident Intake (CII) Email Self-Report Template

Reporter Information

- **Reporter's Name and Title:**
- **Facility/Agency Name:**
- **Facility/Agency Address:**
- **Vendor/Facility ID #:**
- **Primary phone number where you can be reached:**
- **Secondary phone number where you can be reached:**

Resident/Client Information *(If multiple residents are involved, please fill out the Resident/Client Information section for each resident.)*

- **Resident/Client Name:**
- **DOB:**
- **SSN:**
- ***Medicaid #**
- ***Medicare #**
- ***Physical Address:**
 - *For ICF providers only: **dorm name and number:***
- ***Provide the client's payment source and the program the client is in (example: C.B.A, H.C.S, P.H.C, Star-Plus, Family Care, etc.).**
- ***Provide the specific services the client is receiving, including the number of hours per week the services are delivered.**



- **Pertinent Medical Diagnosis:**
- **Is special supervision required, if so please specify:**
- **Level of cognition:**
- **Is there a history of similar or prior incidents, if so please specify:**
- *For ISS providers only:* **name and address of the person responsible for the care of the individual:**

**HCSSA providers only*

Incident Details

- **Date/Time you first learned of incident:**
- **Date/Time the incident occurred:**
- **Brief narrative summary of the reportable incident:**
- **Witnesses name and title:**
- *For ISS providers only:* **At the time of the incident was the individual receiving ISS services?**

Assessment Details

- **The date and time of the assessment:**
- **Name and title of person who completed assessment:**
- **Results of the assessment including extent of injuries. Provide details of any physical harm, pain, or mental anguish including serious bodily injury, or other injuries including but not limited to measurements, location, color of bruises, scratches, lacerations, fractures, changes in resident's behavior that is different from the normal baseline:**
- **Were X-Rays required? If so, provide results:**
- **Type of treatment provided, and when and where treatment was provided:**



- **Was the resident/client sent to the hospital? If so, provide the name and address of the hospital:**
- **Describe treatment/evaluation/diagnosis/results provided at the hospital:**

Alleged Perpetrator

(If alleged perpetrator is not a staff member, please indicate their relationship to resident)

- **Name and title:**
- **Social security number:**
- **Date of birth:**
- ***Phone number:**
- ***Physical address:**
- **Was the alleged perpetrator removed, suspended or terminated?**

**HCSSA providers only*

Actions and Notifications

- **Who did the facility/agency notify about the incident? Ex. physician, family, ombudsman:**
- **Was the incident reported to the police? If so, provide case number:**
- **Provide all steps taken immediately to ensure resident(s) are protected including but not limited to evaluating if resident feels safe, room relocation, increased supervision and other measures to prevent further abuse, neglect, exploitation and misappropriation:**
- **Was an in-service conducted? If so, provide topic of in-service:**
- **Any other relevant information:**