ABUSE, NEGLECT AND EXPLOITATION OR REPORT OF DEATH FORM (SFY 2016)

Always notify DHI/IMB immediately concerning incidents for individuals receiving the Developmental Disabilities Waiver (DDW), DD Mi Via Waiver, or Medically Fragile Waiver, Contact IMB On Call at 1-800-445-6242 and send A/N/E form within 24 hours via http://ane.health.state.nm.us or by fax at 1-800-584-6057.

SECTION 1 - CONSUMER INFORMATION

First Name: Middle Name: Last Name:

Social Security Number: Gender: Date of Birth

Male Female (mm/dd/yyyy)

Street: City State: Zip Code:

Telephone:

Assist with Ambulation
Gait Belt
Walker
Wheelchair

Personal Care
Bathing
Incontinence
Toileting
Toothbrushing

Nutritional Fluid Intake
J-Tube
G-Tube

Transfer
2 or More Persons
Total Care:

None
Other:
High Risk for Aspiration

Method of Communication:

SECTION 2 - DESCRIPTION OF INCIDENT

Report of Death: Death

Type of alleged incident:

Abuse: Physical Sexual Verbal Neglect Exploitation Suspicious Injury Environmental Hazards

Date of Incident: Time:

Location Where Incident Occurred:

Person Responsible for Individual's care at time of incident:

Is this person employed by a provider agency? If so, please state which agency:

What is the person's relationship if not a provider:

Were other individuals present? Yes No Please list other Consumers/Individuals Initials:

Other People?

Name: Title:

Name: Title:

Name: Title:

Name: Title:

To notify Child Protective Services of an incident involving a child, call: 1-800-797-3260
To notify Adult Protective Services of an elder or non-DD waiver adult call 1-866-654-3219

PLEASE DESCRIBE WHAT HAPPENED. BE SPECIFIC ABOUT WHO WAS THERE (by name) AND WHAT YOU SAW AND HEARD.

Before the incident

During the incident

After the incident

SECTION 3 - ADDITIONAL INFORMATION

Current Diagnosis:

Comments:

Person Completing Sections 1 & 2

Confidentiality Desired? Yes No

Name	Agency	Title / Relationship	Phone

Date and Time Completed:

SECTION 4 - AGENCY / FACILITY INFORMATION

Reporting Agency:

Incident Coordinator:

Phone:

SECTION 5 - ADMINISTRATIVE INFORMATION

*Check the applicable box(s) below:

Developmental Disabilities Waiver | Jackson Class Member (JCM) | Yes | No

Medically Fragile Waiver

ICF/IID (JCM Only)

Mi Via Waiver

DD PROGRAMS ONLY: TYPE OF RESIDENTIAL SERVICES RECEIVED BY THIS CONSUMER

Supported Living | Family Living | Respite | Customized in Home Supports

Intensive Medical Living | ICF/MR (Jackson Only) | Mi Via DDW

Was an Immediate Action and Safety Plan Created? Yes No If Yes, please attach documentation (if not already provided)

SECTION 6 - NOTIFICATIONS TO AGENCIES REQUIRED

Legal Guardian: Notified None

Guardian Name: | Phone: | Date: | Time: | Person / Contact:

Street: | City | State: | Zip: | Title:

Independent Case Manager: Notified None

Case Manager Name & Agency: | Phone: | Date: | Time: | Person / Contact:

Street: | City | State: | Zip: | Title:

Other: Notified None

Name: | Phone: | Date: | Time: | Person / Contact:

Street: | City | State: | Zip: | Title:

PERSON COMPLETING SECTIONS 3, 4 & 5

Name | Agency | Title / Relationship | Phone

SECTION 7 - SIGNATURE

Name | Date