



ABUSE, NEGLECT AND EXPLOITATION OR REPORT OF DEATH FORM (SFY 2018)

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	Personal Care	Nutritional Fluid Intake	Transfer	None
Gait Belt	Bathing	J-Tube	2 or More Persons	Other:
Walker	Incontinence	G-Tube		High Risk for Aspiration
Wheelchair	Toileting		Total Care:	
	Toothbrushing			

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: _____

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
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Date and Time Completed:

SECTION 4 - AGENCY / FACILITY INFORMATION

Reporting Agency:

Incident Coordinator:

Phone:

