DETROIT-WAYNE COUNTY COMMUNITY MENTAL HEALTH AGENCY

INCIDENT, ACCIDENT ILLNESS, DEATH OR ARREST REPORT

FACILITY/HOME FACILITY ADDRESS CITY STATE ZIP LICENSEE/ORGANIZATION NAME LICENSEE NUMBER	RESIDENT/RECIPIENT AGE SEX () M () F CASE NUMBER

PERSON INVOLVED/WITNESS(S)

NAME INVOLVED/WITNESS HOME ADDRESS (STREET NAME AND NUMBER) PHONE NUMBER ( )		NAME HOME ADDRESS (STREET NAME AND NUMBER PHONE ( )
DATE OF INCIDENT, ACCIDENT, ILLNESS, DEATH OR ARREST	TIME	LOCATION
EXPLAIN WHAT HAPPENED		
ACTION TAKEN BY STAFF		
ACTION TAKEN TO REMEDY AND/OR PREVENT REOCCURANCE OF INCIDENT, ACCIDENT, ILLNESS OR DEATH		
NAME OF TREATING PHYSICAL/HEALTH CARE/MEDICAL FACILITY HOSPITAL	PHONE NUMBER	DATE AND TIME CARE GIVEN () AM () PM
PHYSICIAN'S DIAGNOSIS OF INJURY/ILLNESS CAUSE OF DEATH IF KNOWN		

PERSON (S) NOTIFIED	NOTIFICATION DATE/TIME	PERSON (S) NOTIFIED	NOTIFICATION DATE/TIME
ADULT FOSTER CARE LICENSING	() AM () PM	ADULT PROTECTIVE SERVICES (IF APPLICABLE)	() AM () PM
PHYSICIAN OR RN (IF APPLICABLE)	() AM () PM	OFFICE OF RECIPIENT RIGHTS (IF APPLICABLE)	() AM () PM
RESPONSIBLE AGENCY	() AM () PM	LAW ENFORCEMENT AGENCY (IF APPLICABLE)	() AM () PM
DESIGNATED REPRESENTATIVE/LEGAL GUARDIAN	() AM () PM	OTHER (PLEASE SPECIFY)	() AM () PM

SIGNATURE OF PERSON COMPLETING REPORT	PRINT NAME AND TITLE	DATE
SIGNATURE OF LICENSEE/ADMINISTRATOR	PRINT NAME AND TITLE	DATE

COPIES OF COMPLETED REPORT TO BE SENT TO:

DESIGNATED REPRESENTATIVE/LEGAL GUARDIAN, CONTRACT/RESPONSIBLE AGENCY, OFFICE OF RECIPIENT RIGHTS, AND DSS-AFC LICENSING DIVISION-IN ACCORDANCE WITH AFC LICENSING REQUIREMENTS, AND CMH RECIPIENT RIGHTS POLICIES.

CMH 2501

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