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Provider Name: _____ **Vendor / ID No.:** _____

Street Address: _____

City: _____

Telephone: () _____

Fax: () _____

Investigation Report Fax Cover Sheet

Date: _____

To: DADS Consumer Rights and Services Section _____

Attention: Intake Coordinator _____

Fax Area Code and Telephone No. 1-877-438-5827 _____

Regarding DADS Intake ID No.: _____

Pages (including cover): _____

Thank you,

Name: _____

Title: _____

Telephone: () _____

Provider Investigation Report

Fax this report to: 1-877-438-5827 (toll free)
or

Mail this report to: Texas Department of Aging and Disability Services, Consumer Rights and Services
Section, E-249, P.O. Box 149030, Austin, TX 78714-9030

**Note to reporter:
Do not mail if faxed.**

DADS Intake ID No.	Date Reported to DADS (800) 458-9858	Time Reported : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
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Provider Type	Vendor / ID No.	Telephone No. () -
Name	Fax () -	
Street Address	City	ZIP Code

Incident Category

- Death Abuse Neglect Exploitation Missing Resident/Client Drug Diversion Fire Bomb Threat
- Tornado Flood Emergency Power Failure Sprinkler System Failure Fire Alarm Failure Firearms in the Building
- Air Conditioning Failure if Outdoor Temperature is or will be 90 Degrees or Above
- Heating System Failure if Outdoor Temperature is 65 Degrees or Below
- Others, specify

Who made the allegation? <input type="checkbox"/> Client/Resident <input type="checkbox"/> Family <input type="checkbox"/> Other	When?
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Incident Date	Time : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Location
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Client(s)/Resident(s) Involved, Including Alleged Victim(s) or Alleged Aggressor(s)

Name	<input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security No.	Date of Birth
Functional Ability: <input type="checkbox"/> Total assistance <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> No assistance	Level of Supervision: <input type="checkbox"/> No special supervision <input type="checkbox"/> Within eyesight <input type="checkbox"/> Within hearing <input type="checkbox"/> Within arm's length		
<input type="checkbox"/> Within specified distance: _____		<input type="checkbox"/> Specified observation time frame: _____	
Other: _____			
Independently ambulatory <input type="checkbox"/> Y <input type="checkbox"/> N	Interviewable <input type="checkbox"/> Y <input type="checkbox"/> N	Capacity to make informed decisions <input type="checkbox"/> Y <input type="checkbox"/> N	
History of <input type="checkbox"/> Combativeness <input type="checkbox"/> Verbal aggression <input type="checkbox"/> Physical aggression <input type="checkbox"/> Sexual misconduct	<input type="checkbox"/> Wandering <input type="checkbox"/> Wearing wander guard at time of incident <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Similar allegations		
Other pertinent history: _____			
Name	<input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security No.	Date of Birth
Functional Ability: <input type="checkbox"/> Total assistance <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> No assistance	Level of Supervision: <input type="checkbox"/> No special supervision <input type="checkbox"/> Within eyesight <input type="checkbox"/> Within hearing <input type="checkbox"/> Within arm's length		
<input type="checkbox"/> Within specified distance: _____		<input type="checkbox"/> Specified observation time frame: _____	
Other: _____			
Independently ambulatory <input type="checkbox"/> Y <input type="checkbox"/> N	Interviewable <input type="checkbox"/> Y <input type="checkbox"/> N	Capacity to make informed decisions <input type="checkbox"/> Y <input type="checkbox"/> N	
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Name	<input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security No.	Date of Birth
Functional Ability: <input type="checkbox"/> Total assistance <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> No assistance	Level of Supervision: <input type="checkbox"/> No special supervision <input type="checkbox"/> Within eyesight <input type="checkbox"/> Within hearing <input type="checkbox"/> Within arm's length		
<input type="checkbox"/> Within specified distance: _____		<input type="checkbox"/> Specified observation time frame: _____	
Other: _____			
Independently ambulatory <input type="checkbox"/> Y <input type="checkbox"/> N	Interviewable <input type="checkbox"/> Y <input type="checkbox"/> N	Capacity to make informed decisions <input type="checkbox"/> Y <input type="checkbox"/> N	
History of <input type="checkbox"/> Combativeness <input type="checkbox"/> Verbal aggression <input type="checkbox"/> Physical aggression <input type="checkbox"/> Sexual misconduct	<input type="checkbox"/> Wandering <input type="checkbox"/> Wearing wander guard at time of incident <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Similar allegations		
Other pertinent history: _____			

DADS Intake ID No.

Alleged Perpetrator(s) (AP)

(If alleged perpetrator is somebody other than a staff member, indicate this individual's relationship to the client, **example:** relative, visitor, etc.)

Name	Date of Birth	Social Security No.	License/Certificate No.

How was the AP identified? By name By description Other: _____
 Perpetrator: Denied Confirmed History of similar allegations? Yes No

Did investigation reveal the presence of a witness? Yes No
 Statement attached (signed and notarized, if possible) Yes No

Witness(es) Name	Client/Patient/Family/Staff/Other	Address	Area Code and Telephone No.
			() -
			() -
			() -
			() -

Description of the Allegation

Injury/Adverse Effect? Yes No

Description of Injury

Assessment Date Time : A.M. P.M.

Description of Assessment

Treatment provided? Yes No Treatment/Transfer Date Time : A.M. P.M.

Treatment location: In-House Yes No Offsite City

Provider Response

DADS Intake ID No.

Investigation Summary (attach additional sheets, as necessary)

Investigation Findings
 Confirmed Unconfirmed Inconclusive Unfounded

Provider Action Taken Post-Investigation

Signature	Title
Printed Name	Date