SUPPORTIVE LIVING PROGRAM PROVIDER
PRELIMINARY INCIDENT REPORT

Building: _____ Contact Person: _____

Address: _____ Telephone Number: _____
_____

Date incident occurred: _____ Time: _____ a.m./p.m.

Type of Emergency	Specific Resident Incident	Outside Service
❑ Earthquake ❑ Fire/fire alarm ❑ Flood ❑ Power Outage ❑ Tornado ❑ Other _____	❑ Abuse ❑ Theft or other crime ❑ Death ❑ Neglect ❑ Other _____	❑ Ambulance ❑ Coroner ❑ Fire Department ❑ Hospital ❑ Police ❑ Other _____

Date/time local law enforcement notified: _____ _____ a.m./p.m.

Date/time other state/local agencies notified: _____ _____a.m./p.m

Date/time Managed Care plan(s) notified, note name(s) of Managed Care plan(s):

_____ _____

Name(s) of resident(s) involved (attach a separate list if necessary, or state "entire facility")
Include "M" (Medicaid) or "P" (Private) after each name indicating payer source.

_____ _____

_____ _____

# of Injuries: _____ # of Deaths: _____

Location(s) of displaced resident(s): _____
_____

Type of assistance needed: _____
Narrative of incident and facility response (attach 2nd page if necessary):

_____

_____

_____

_____

_____

_____

_____

Signature Title Date

Rev. 6/27/18

(HFS-BLTC FAX: 217-557-5061)