NEW YORK STATE DEPARTMENT OF HEALTH
CERTIFIED MEDICAL RESPITE PROGRAM
Incident Report

Instructions

If certain serious incidents occur, medical respite programs (MRPs) must:

- Notify New York State Department of Health (NYSDOH) by phone, at 518-408-4079; **and**
- Fill out and submit this incident report to MRProgram@health.ny.gov.

See the table below for incident types that require NYSDOH notification and reporting, and the deadlines for each.

INCIDENT TYPE	Notify NYSDOH	Submit Incident Report
A recipient's location is unknown for more than 24 hours	First working day	Within 5 working days
A recipient assaults someone or is a victim of assault	Immediately	Within 24 hours
A recipient attempts or dies by suicide	Immediately	Within 24 hours
A recipient dies by means other than suicide	Immediately	Within 24 hours
There is evidence of recipient abuse	Immediately	Within 24 hours
A recipient's behavior directly impairs the safety of self or others or substantially interferes with operation of the MRP	--	Within 5 working days
A recipient is involved in an incident (on or off MRP campus) that results in the recipient's need for medical attention	--	Within 5 working days
A felony may have been committed by or against a recipient*	Immediately	Within 24 hours

**The MRP must also notify law enforcement as soon as possible.*

If NYSDOH staff are not available to take your phone call, please leave a detailed message. The message should include a description of the incident; the current status of the incident (e.g., resolved or ongoing); and the name and phone number of a contact person at the MRP.

This form satisfies incident reporting requirements for NYSDOH/Office of Health Insurance Programs only. If you are reporting on behalf of a MRP that is also certified, licensed, or otherwise affiliated with another state agency, please contact that agency directly for guidance on incident reporting requirements.

Completed copies of this incident report must be retained in the record(s) of involved recipient(s) for 6 years following discharge or death of the recipient(s) and for 10 years in program records.

MEDICAL RESPITE PROGRAM INFORMATION		
MRP Name		
MRP Address		
City	**Zip Code**	**County**
MRP Phone Number		

INCIDENT INFORMATION		
What type of incident occurred?		
When did the incident occur?	Date:	Time:
Where did the incident occur?		

Which agencies responded to the incident? *(Select all that apply)*

☐ Police ☐ EMS ☐ Fire Department ☐ Adult Protective Services ☐ Other: ☐ None

Was the MRP director or another appropriate staff person notified? ○ Yes ○ No

If yes, provide the full name of the staff person notified:

Date of notification: Time of notification:

Was NYSDOH notified by phone? ○ Yes ○ No

Date of notification: Time of notification:

☐ Not applicable

INJURY

Provide the full name of the injured individual:

What is the affiliation of the injured individual? *(Select one)*

○ Recipient ○ Staff ○ Visitor ○ Other:

Briefly describe type of injury:

Did an EMS transport occur? ○ Yes ○ No ○ Injured individual refused transport

If **yes**, provide the name of the hospital the individual was transported to:

☐ Not applicable

EMERGENCY RESPONDER INFORMATION

Responder Type	Time Called	Time Arrived	Full Name	Badge #	Unit

☐ Not applicable

RECIPIENTS INVOLVED IN INCIDENT

Full Name	Room, Bed, or Unit #	Social Care Network	Statement Taken?

Were any recipients transferred as a result of the incident?* ○ Yes ○ No

Were any recipients discharged as a result of the incident?* ○ Yes ○ No

*If **yes**, attach appropriate documentation.

☐ Not applicable

STAFF INVOLVED IN INCIDENT

Full Name	Title	Statement Taken?

Were any staff required to leave the MRP site following the incident? ○ Yes ○ No

If **yes**, list staff:

☐ Not applicable

WITNESSES *(Not directly involved in incident)*		
Full Name	**Affiliation (Recipient, Staff, Visitor, Other)**	**Statement Taken?**

DESCRIPTION OF INCIDENT ***(Who, What, Where, When)***

IMMEDIATE ACTION TAKEN

RESOLUTION

FOLLOW-UP

Name and Title of Staff Completing Incident Report:

Staff Signature: _____ Date: _____

Program Director's Signature: _____ Date: _____

Please attach additional copies of this page as needed to record all witness statements.

STATEMENT #:

Full name of witness:

Affiliation of witness: ○ Recipient ○ Staff ○ Visitor ○ Other:

Select the appropriate box(es) below to indicate whether the witness was:

☐ Injured ☐ Provided medical attention ☐ Transferred ☐ Discharged

Statement:

STATEMENT #:

Full name of witness:

Affiliation of witness: ○ Recipient ○ Staff ○ Visitor ○ Other:

Select the appropriate box(es) below to indicate whether the witness was:

☐ Injured ☐ Provided medical attention ☐ Transferred ☐ Discharged

Statement:

STATEMENT #:

Full name of witness:

Affiliation of witness: ○ Recipient ○ Staff ○ Visitor ○ Other:

Select the appropriate box(es) below to indicate whether the witness was:

☐ Injured ☐ Provided medical attention ☐ Transferred ☐ Discharged

Statement:

STATEMENT #:

Full name of witness:

Affiliation of witness: ○ Recipient ○ Staff ○ Visitor ○ Other:

Select the appropriate box(es) below to indicate whether the witness was:

☐ Injured ☐ Provided medical attention ☐ Transferred ☐ Discharged

Statement: