



# ABUSE, NEGLECT AND EXPLOITATION OR REPORT OF DEATH FORM (SFY 2017)

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:

SECTION 5 - ADMINISTRATIVE INFORMATION

\*Check the applicable box(s) below:

- Developmental Disabilities Waiver      Jackson Class Member (JCM)    Yes    No
- Medically Fragile Waiver
- ICF/IID (JCM Only)
- Mi Via Waiver

DD PROGRAMS ONLY: TYPE OF RESIDENTIAL SERVICES RECEIVED BY THIS CONSUMER

- Supported Living    Family Living    Respite    Customized in Home Supports
- Intensive Medical Living    ICF/MR (Jackson Only)    Mi Via DDW

Was an Immediate Action and Safety Plan Created?    Yes    No    If Yes, please attach documentation (if not already provided)

SECTION 6 - NOTIFICATIONS TO AGENCIES REQUIRED

Legal Guardian:    Notified    None

Guardian Name:                                      Phone:                                      Date:                                      Time:                                      Person / Contact:

Street:                                      City                                      State:                                      Zip:                                      Title:

Independent Case Manager:    Notified    None

Case Manager Name & Agency:                                      Phone:                                      Date:                                      Time:                                      Person / Contact:

Street:                                      City                                      State:                                      Zip:                                      Title:

Other:    Notified    None

Name:                                      Phone:                                      Date:                                      Time:                                      Person / Contact:

Street:                                      City                                      State:                                      Zip:                                      Title:

PERSON COMPLETING SECTIONS 3, 4 & 5

Name                                      Agency                                      Title / Relationship                                      Phone

SECTION 7 - SIGNATURE

Name                                      Date