

Appendix A: Incident Report Maine Caring Families

<input type="checkbox"/> Medication Prescribing Error <input type="checkbox"/> Medication Administering Error <input type="checkbox"/> Medication Refusal	<input type="checkbox"/> Harming Self Physical Intervention Used <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Harming Others Physical Intervention Used <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Accident/Injury <input type="checkbox"/> Runaway <input type="checkbox"/> Other:
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Child's Name: \_\_\_\_\_ DHS Caseworker: \_\_\_\_\_

Foster Parent(s): \_\_\_\_\_ MCF Regional Coordinator: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Date Report Written: \_\_\_\_\_ Written By: \_\_\_\_\_

Where Incident Occurred: \_\_\_\_\_

People Involved: \_\_\_\_\_

Incident Precursors: \_\_\_\_\_

Incident: \_\_\_\_\_

Resolution: \_\_\_\_\_

Date/Time DHS Caseworker Notified: \_\_\_\_\_ If DHS Caseworker Not Contacted, Reason

Why: \_\_\_\_\_

Date/Time Support Worker Notified: \_\_\_\_\_ If Support Worker Not Contacted, Reason

Why: \_\_\_\_\_

Comments: (continue on back if necessary): \_\_\_\_\_

Foster Parent signature : \_\_\_\_\_ Date: \_\_\_\_\_

- \*\*\*1.) Please send to Regional Coordinator, within 2 working days.
- 2.) Please discuss with your Support Worker and provide them with a copy.
- 3.) Your Regional Coordinator will send a copy to your Licensing Worker, Child's Caseworker and Maine Caring Families Agency Program Coordinator.

Date Distributed by Regional Coordinator: \_\_\_\_\_