ATTACHMENT A- Critical Incident Reporting Form
Designated Agency or Specialized Services Agency Report
Vermont Department of Disabilities, Aging & Independent Living

The Department of Disabilities Aging & Independent Living is to be notified of a significant event that occurs in a Designated/Specialized Services Agency. A verbal report will be made within 24 hours from the agency's knowledge of incident to the DAIL 24-hour CIR Line at **802-241-2678** for incidents of Untimely or Suspicious Death or Missing Person. Reports of Potential Media Involvement need to be made directly to the DDSD Director/ASD Quality & Provider Relations Director upon the Agency becoming aware of the incident. This reporting form must be completed for all types of critical incidents, and submitted by scanning/electronic upload via GlobalSCAPE, DAIL's secure FTP site:

https://gs-sftp.ahs.state.vt.us/EFTClient/Account/Login.htm .

or faxed to DAIL within 2 business days from the agency's knowledge of the incident to **DDSD at 802 241-0410/ASD at 802-241-0385**

Name of Individual involved:	**Date of Incident:**
Date of Birth	**Time:**
Agency Name:	**Location:**
Program (check all that apply): ☐ DS ☐TBI ☐MFP ☐AFC	

Type of incident:

☐ Death: ☐ Untimely/Suspicious ☐ Natural	☐ Missing Person
☐ Potential Media Involvement	☐ Report of Abuse, Neglect, Exploitation/ Use of a Prohibited Practice
☐ Criminal Activity/Incarceration	☐ Medical Emergency
☐ Seclusion Restraint: ☐ Mechanical ☐ Physical ☐ Chemical	☐ Other (Includes Action by Paid Staff/Provider/Worker paid by DAIL funds:
☐ Suicide Attempt	

Persons who witnessed or were involved in the incident:

Description of incident (What happened before, during and after the incident; identify precipitants, interventions used by staff to attempt to prevent/manage the incident, and description of behaviors observed during the incident):

Action(s) taken as a result of the incident. :

Describe any planned follow up in response to the incident:

Persons and agencies notified (include when and how notified; if an agency, name of staff to whom report given)

Person reporting, Name/signature: **Date:**
Phone number: (**REQUIRED**)
Supervisor/QDDP (DDSD)/CM/SC (MFP/AFC) review of Incident/comments:
Supervisor/QDDP (DDSD)/CM/SC (MFP/AFC) Name/Signature: **Date:**

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