NEW MEXICO DEPARTMENT OF HEALTH

ABUSE, NEGLECT AND EXPLOITATION OR REPORT OF DEATH FORM (SFY 2020)

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: ○Male ○Female | Date of Birth (mm/dd/yyyy)

Street: | City | State: | Zip Code:

Telephone:

- ☐ Assist with Ambulation
- ☐ Gait Belt
- ☐ Walker
- ☐ Wheelchair
- ☐ Personal Care
- ☐ Bathing
- ☐ Incontinence
- ☐ Toileting
- ☐ Toothbrushing
- ☐ Nutritional Fluid Intake
- ☐ J-Tube
- ☐ G-Tube
- ☐ Transfer
- ☐ 2 or More Persons
- ☐ Total Care:
- ☐ None
- ☐ Other:
- ☐ High Risk for Aspiration

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:

To notify Child Protective Services of an incident involving a child, call: 1-800-797-3260
To notify Adult Protective Services of an elder or non-DD waiver adult call 1-866-654-3219

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

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