

**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**

|  |                          |
|--|--------------------------|
| <b>Name of Individual involved:</b>  | <b>Date of Incident:</b> |
| <b>Date of Birth</b>   | <b>Time:</b>             |
| <b>Agency Name:</b>  | <b>Location:</b>         |
| <b>Program (check all that apply):</b><br><input type="checkbox"/> DS <input type="checkbox"/> TBI <input type="checkbox"/> MFP <input type="checkbox"/> AFC |                          |

**Type of incident:**

|   |  |
|---|--|
| <input type="checkbox"/> Death: <input type="checkbox"/> Untimely/Suspicious <input type="checkbox"/> Natural   | <input type="checkbox"/> Missing Person  |
| <input type="checkbox"/> Potential Media Involvement  | <input type="checkbox"/> Report of Abuse, Neglect, Exploitation/<br>Use of a Prohibited Practice     |
| <input type="checkbox"/> Criminal Activity/Incarceration  | <input type="checkbox"/> Medical Emergency   |
| <input type="checkbox"/> Seclusion Restraint: <input type="checkbox"/> Mechanical<br><input type="checkbox"/> Physical<br><input type="checkbox"/> Chemical | <input type="checkbox"/> Other (Includes Action by Paid<br>Staff/Provider/Worker paid by DAIL funds: |
| <input type="checkbox"/> 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:**

