



Georgia Department of Human Services

DEPARTMENT OF HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL: RESIDENTIAL CHILD CARE LICENSING

INCIDENT INTAKE INFORMATION FORM

This form is to be filled out completely and submitted via email to RCCReports@dhs.ga.gov. Hand written and phone reports are not accepted.

Facility ID #: CCI00 CPA00 CPFC00 OCCP00 OTP00 MH00 CTCC00 Date:

Facility's Licensed Name: CPA Satellite Office:

Facility's Full Site Address: County:

Phone: E-mail: Was the Director notified of incident? Yes No

REPORTER

Full Name (First & Last): Position/Title:

Work Phone: Cell Phone: E-mail:

REASON FOR REPORT (Check all that apply in the boxes below)

Table with 6 columns: Physical Abuse Allegation, Serious Accident/Injury, Suicidal Actions, Emergency Safety Intervention (ESI), Temporary Closure of a Living Unit, Sexual Abuse and/or Exploitation Allegation, Neglect, Law Enforcement, ESI with Injury Beyond First Aid, Unplanned Hospital or Urgent Care, CPS Involvement, Other Serious Occurrence.

CPS NOTIFICATION (REQUIRED FOR ALL PHYSICAL/ SEXUAL ABUSE AND NEGLECT ALLEGATIONS)

Was a CPS referral made to the county of occurrence or the CPS Hotline? Yes No Date of Report:

CHILD/ RESIDENT (List each child involved in this incident. Use page three for space for additional children's information if needed)

#1: Child's Full Name:

Date of Admission: Date of Birth: Male Female

DFCS County of Custody: Case Manager Name: Phone:

DJJ County: Probation Officer Name: Phone:

Parent / Guardian notified: Yes No Date Notified: Time Notified:

#2: Child's Full Name:

Date of Admission: Date of Birth: Male Female

DFCS County of Custody: Case Manager Name: Phone:

DJJ County: Probation Officer Name: Phone:

Parent/ Guardian notified: Yes No Date Notified: Time Notified:

FOSTER PARENT/ADOPTIVE PARENT WHERE CHILD WAS PLACED DURING THE INCIDENT (Foster Care/Adoption Only)

Full Name of Foster Mother: Full Name of Foster Father:

Full Address: County:

Home Phone: Cell Phone: Best Time to Reach:

WITNESS

Full Name: _____ Staff Foster Parent Child Other : _____
Work Phone: _____ Cell Phone: _____ Best Time to Reach: _____

INCIDENT

Date of Incident: _____ Time of Occurrence: _____ Place of occurrence: _____
Staff/FP to Child ratio at Time of Incident: _____ Full names of adults responsible for children at the time of the incident: _____

WHAT HAPPENED DURING THE INCIDENT: Include: A) Precipitating Factors; B) What occurred and the timeline; C) Staff/Foster Parent Involvement; D) Child Injury. If an ESI was part of this incident then add this information to the ESI list on page three. If this was an ESI with injury beyond first aid or a child has alleged maltreatment during the ESI then a full report is required. *(Use page three for additional space if needed.)*

A) Precipitating Factors (Describe the events that preceded this incident that may have contributed to the incident):

B) What Occurred and Timeline (Describe what happened during the actual incident and the sequence of events):

C) Staff/Foster Parent Involvement (Describe what actions staff/foster parent took during this event including any notifications made:

D) Child injury? Yes No (If yes, include how the injury occurred, who may have caused the injury, the date medical attention was given and by whom, the diagnosis and the extent of the medical care. Was the injury from an ESI and requiring more than first aid: Yes No

SAFETY PLAN: STEPS TAKEN BY FACILITY TO PREVENT FUTURE INCIDENTS: Immediate and long term safety plans that ensure the safety of all children in your care. If there is an alleged perpetrator then include a plan regarding that person's interactions with children in care. Additionally, a detailed investigative report which includes steps taken by the facility/agency to prevent similar incidents from occurring is to be completed within five working days. The investigative report will be kept with the incident report unless requested by RCCL. *Use page three for additional space if needed.*

NAME OF PERSON(S) ALLEGED TO BE RESPONSIBLE FOR INJURY/ MALTREATMENT: (List all involved)

Full Name: _____ Staff/Foster Parent Child Other

Full Name: _____ Staff/Foster Parent Child Other

Does this person still have access to children in care and/or are there still foster children in this foster home? Yes No
Was this plan approved by the custody holder? Yes No *If yes, add the approved plan to the Safety Plan section.*

WHAT HAPPENED DURING THE INCIDENT: A-D (Continuation from page two.)

SAFETY PLAN (Continuation from page two and/or additional space for children's information.)

EMERGENCY SAFETY INTERVENTION (ESI) REPORTS (Use this format to document each ESI for your agency and the specific child. If this is the first report regarding this child then please complete the identifying information on page one.)

Example: This is the agency's # ESI and the # for (child's name) for the month of X (calendar month), MM/DD/YYYY (date of ESI).

This is the agency's _____ ESI and the _____ for _____ for the month of _____, date: _____.

This is the agency's _____ ESI and the _____ for _____ for the month of _____, date: _____.

This is the agency's _____ ESI and the _____ for _____ for the month of _____, date: _____.

This is the agency's _____ ESI and the _____ for _____ for the month of _____, date: _____.

This is the agency's _____ ESI and the _____ for _____ for the month of _____, date: _____.

This is the agency's _____ ESI and the _____ for _____ for the month of _____, date: _____.

This is the agency's _____ ESI and the _____ for _____ for the month of _____, date: _____.