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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-02208 (03/2024) | **STATE OF WISCONSIN**Page 1 of 2 |
| **ASSISTED LIVING FACILITY SELF-REPORT** |
| * Refer to DQA publication P-02007*Reporting Requirements for Assisted Living Facilities,*for reporting requirements pertaining to reports submitted to the Division of Quality Assurance (DQA).
* If the type of report being filed does not require a specific form, this form may be used for reporting to DQA.
* Submit this signed and fully completed form to your DQA Regional Office. For regional office contact information see: <https://www.dhs.wisconsin.gov/dqa/bal-regionalmap.htm>
 |
| Name – Facility       | Facility No.      |
| Address – Facility      | City       | State    | Zip Code      |
| Reason for Report (Click to Select from Dropdown List)  | Outcome(Click to Select from Dropdown List) | Write in Additional Outcomes:      | Date of Report*(MM/dd/yyyy)*      |
| **INCIDENT INFORMATION** |
| ***Use page 2 to provide additional information, as needed. Attach supporting documentation, as needed.*** |
| Date – Incident *(MM/dd/yyyy)* | Time – Incident  | [ ]  AM [ ]  PM |
| **Involved Persons** *(List all residents, staff, guardians, family, etc. involved and their relationship to facility or resident.)* |
| **Name** | **Relationship to Facility or Resident** |
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| **Incident Description** *(Include place, individuals involved, details of the occurrence, historical/background information.)* |
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| **Incident Outcome** |
|       |
| **Action Taken to Ensure Resident’s Health, Safety, and Well-Being** |
|       |
| **Person Submitting Report** |
| Name – Person Submitting Report *(Print or type.)*      | Title      |
| **SIGNATURE** – Person Submitting Report | Phone No.      |
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