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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-03145 (04/2023) | **STATE OF WISCONSIN**DHS 105.14Page 1 of 2 |
| **ADULT DAY CARE CENTER SELF-REPORT** |
| * This form may be used by Adult Day Care Centers (ADCC) for required reporting to the Division of Quality Assurance (DQA). See reporting requirements at [DHS 105.14(2)(L)](https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/14/2/l).The information in this report will be used by DQA only for the purpose of reviewing or investigating reported incidents.
* This form is **not** used for reporting a death related to psychotropic medication, restraint, or suicide. Reporting requirements and forms for reportable deaths are found at: <https://dhs.wisconsin.gov/regulations/report-death/proc-reportingdeath.htm>.
* Submit this signed and fully completed form to DHSDQABHSACCS@dhs.wisconsin.gov.
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| Name – Facility  | License No. – Facility |
| Address – Facility | City | State | Zip Code |
| Reason for Report | 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** |
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| **Action Taken to Ensure Resident’s Health, Safety, and Well-Being** |
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| **Person Submitting Report** |
| Name – Person Submitting Report *(Print or type.)* | Title |
| **SIGNATURE** – Person Submitting Report | Telephone No. |
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