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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-03145 (04/2023) | | | **STATE OF WISCONSIN**  DHS 105.14  Page 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](mailto:DHSDQABHSACCS@dhs.wisconsin.gov). | | | | | | |
| 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.)* | | | | | | |
|  | | | | | | |
| **Incident Outcome** | | | | | | |
|  | | | | | | |
| **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. | | | | |
| **ADULT DAY CARE CENTER SELF-REPORT** | | | | | | |
| ***Use page 2 to provide additional information, as needed. Attach supporting documentation, as needed.*** | | | | | | |
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