DMHA

INCIDENT, FOLLOW-UP AND COMPLAINT REPORTING USER GUIDE

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Incident Reports

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- Select Initial Incident Report from menu

State of Indiana
DIVISION OF MENTAL HEALTH AND ADDICTION

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Welcome to the DMHA Incident, Follow-Up and Complaint Reporting website

NOTICE TO USERS: Please be advised, the Indiana Office of Technology (IOT) only supports Internet Explorer. If you access this site via Mozilla (Firefox), Safari, Chrome or some other agent, errors may occur. Thank you.

This website is for filing appropriate initial incident, follow-up and complaint reports as required by the State of Indiana Division of Mental Health and Addiction. Please review the User Guide for additional assistance and explanation of each web form.

This site is maintained by the Division of Mental Health and Addiction. Please report any technical problems with the website by sending an e-mail to DMHA.Admin@fssa.in.gov. Please direct policy related questions to DMHAyouthservices@fssa.in.gov.

- Fill out all necessary information in each section
  - ➢ Participant Data
  - ➢ Informed Data
  - ➢ Reporting Person & Agency
  - ➢ Incident Information

Participant Data
Required information:

- First & Last Name
- Gender
- DOB
- Address, City, State, Zip, County
- Funding Source

Participant Data

Field	Value	Field	Value
Participant ID		ID Type	-- Select Type --
Last Name*	Bestie	First Name*	Penny
Gender*	Female	DOB*	12/02/1990
Address*	1724 Los Robles Dr.	City*	Fishers
State*	IN	Zip*	46038
County*	Hamilton	Funding Source*	1915(i) CMHW Services

If you are attempting to report a MFP_PRTF Incident, please go to the IFUR website (https://ddrsprovider.fssa.in.gov/IFUR/).
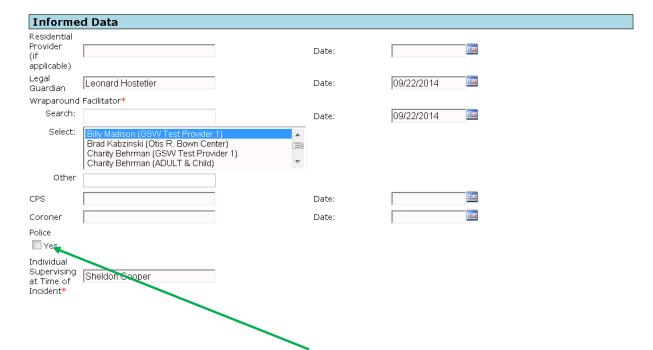
If the Incident involves MFP_PRTF you must go to a different website.

Informed Data

Required information:

- Wraparound Facilitator & date
- Supervising individual & date

If the incident involved law enforcement check 'Yes' and then answer the following questions that appear

Reporting Person & Agency

Required information:

- First & Last name of person reporting
- Phone number
- Email
- Reporting Agency
- Provider present/involved
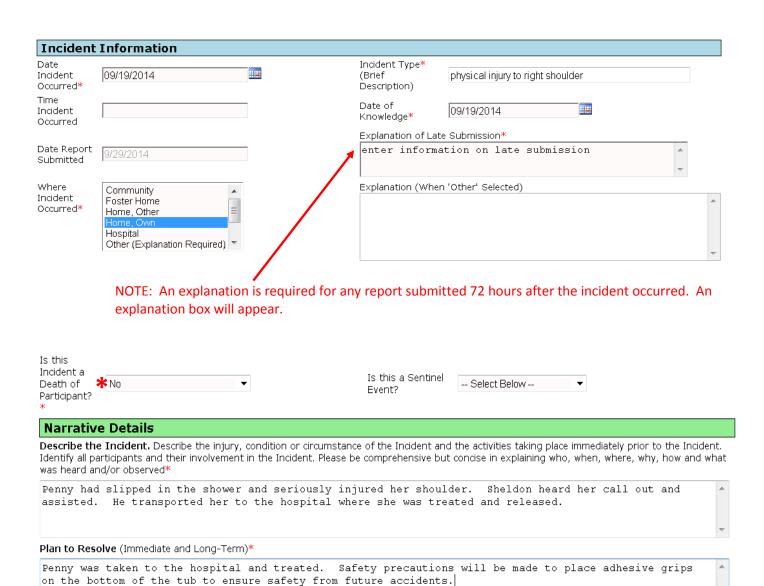

NOTE: If a provider was present the following information screen will appear and will require completion

Incident Information

Required information:

- Date incident occurred
- Incident type
- Date of Knowledge
- Where Incident occurred
- Did incident result in death?
- Description of incident
- Immediate and long-term plans of resolution

Incident Information

Date Incident Occurred*	09/19/2014	Incident Type* (Brief Description)	physical injury to right shoulder
Time Incident Occurred		Date of Knowledge*	09/19/2014
Date Report Submitted	9/29/2014	Explanation of Late Submission*	enter information on late submission
Where Incident Occurred*	Community / Foster Home / Home, Other / Home, Own / Hospital / Other (Explanation Required)	Explanation (When 'Other' Selected)	

NOTE: An explanation is required for any report submitted 72 hours after the incident occurred. An explanation box will appear.

| Is this Incident a Death of Participant?* | *No | Is this a Sentinel Event? | -- Select Below -- |

Narrative Details

Describe the Incident. Describe the injury, condition or circumstance of the Incident and the activities taking place immediately prior to the Incident. Identify all participants and their involvement in the Incident. Please be comprehensive but concise in explaining who, when, where, why, how and what was heard and/or observed*

Penny had slipped in the shower and seriously injured her shoulder. Sheldon heard her call out and assisted. He transported her to the hospital where she was treated and released.

Plan to Resolve (Immediate and Long-Term)*

Penny was taken to the hospital and treated. Safety precautions will be made to place adhesive grips on the bottom of the tub to ensure safety from future accidents.

*NOTE: If the incident resulted in the death of the participant the following information boxes will appear

Is this Incident a Death of Participant? * [Yes ▼]   Is this a Sentinel Event? [No ▼]

Narrative Death Details

Date of Death [🗓]   Place of Death* [-- Select Below -- ▼]
Explanation (When 'Other' Selected) [ ]

Time of Death [ ]

Circumstances immediately preceding the death, if known:* [▲ ▼]

Describe all life-saving measures, IF ANY WERE APPLICABLE, attempted at time of death (i.e., CPR administered, 911 called, transported to hospital, etc.), if known* [▲ ▼]

Circumstances immediately following the death or discovery of the death, if known:* [▲ ▼]

What was the preliminary cause of death?* [▲ ▼]

If no life-saving, explain why not (i.e., no-code status, do not resuscitate (DNR) order, etc.), if known [▲ ▼]

Was there a DNR status?* [-- Select Below -- ▼]

Description of event(s) surrounding this death is as follow* [▲ ▼]

Was Death Expected?* [-- Select Below -- ▼]

[**Complete/Preview**]   [**Cancel**]

When all required information has been entered select 'Complete/Preview'

If there is missing information or errors a warning message will appear

Missing / Invalid Items

- Please enter both Legal Guardian name and date.
- Date Report Submitted is more than 72 hours after Date incident occured. Please provide explanation for late submission.

Submitting Incident Reports

Review your completed report
if any changes are necessary select 'Go Back'

DMHA – INITIAL INCIDENT REPORT

Go Back To Change Entries

Participant Data

Participant ID		ID Type	N/A
Last Name	bestie	First Name	penny
Gender	Female	DOB	12/02/1990
Address	1724 Los Robles	City	Fishers
State	IN	Zip	46038
County	Hamilton	Funding Source	1915(i) CMHW Services

Informed Data

Residential Provider (if applicable)		Date:	
Legal Guardian	Leonard Hostetler	Date:	09/22/2014
Wraparound Facilitator	Billy Madison (GSW Test Provider 1)	Date:	09/22/2014
WF (Other)			
CPS		Date:	
Coroner		Date:	
Police		Date:	
Handcuffed?	N/A	Tasered?	
Individual Supervising at Time of Incident	Sheldon Cooper		

Reporting Person & Agency

Last Name	Farrah-Fowler	First Name	Amy
Phone	(317) 254-2635	Email	Sheldonsgal@gswtest.com
Reporting Agency/Individual	GSW Test Provider 1 – 123456789A		
Other			
Was a Provider present/involved at the time of the incident? Unknown			

Incident Information

Date Incident Occurred	09/19/2014	Incident Type (Brief Description)	physical injury to right shoulder
Time Incident Occurred		Date of Knowledge	09/19/2014
Date Report Submitted	9/29/2014	Explanation of Late Submission enter information on late submission	
Where Incident Occurred	Home, Own	Explain	
Is this Incident a DOP?	No	Is this a Sentinel Event?	No

Narrative Details

Describe the Incident. Describe the injury, condition or circumstance of the Incident and the activities taking place immediately prior to the Incident. Identify all participants and their involvement in the Incident. Please be comprehensive but concise in explaining who, when, where, why, how and what was heard and/or observed

Penny had slipped in the shower and seriously injured her shoulder. Sheldon heard her call out and assisted. He transported her to the hospital where she was treated and released.

Plan to Resolve (Immediate and Long-Term)

Penny was taken to the hospital and treated. Safety precautions will be made to place adhesive grips on the bottom of the tub to ensure safety from future accidents.
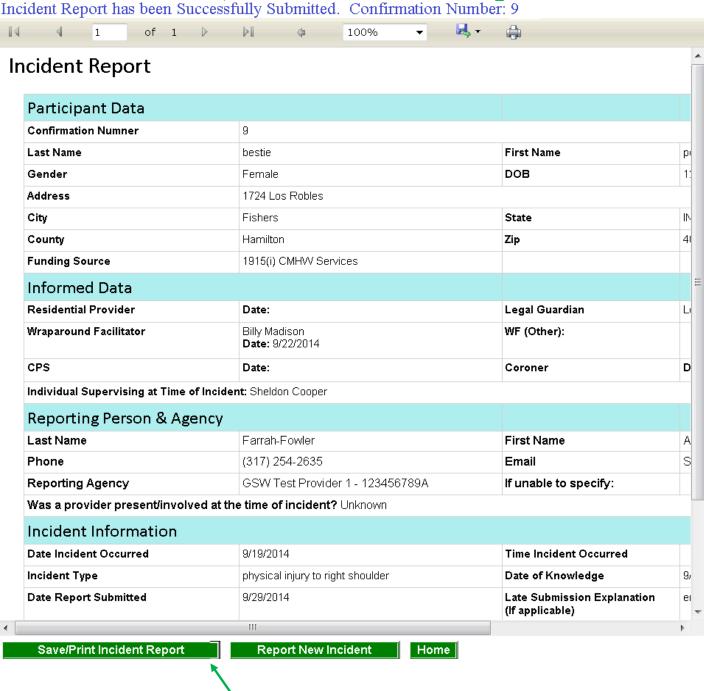
Submit Form   Cancel

If no changes are required select 'Submit Form'

Saving/Printing Incident Reports

After your report is submitted the following screen will appear showing two important things

- Confirmation number
- Successfully submitted message

DMHA – INITIAL INCIDENT REPORT

Incident Report has been Successfully Submitted. Confirmation Number: 9

| | | | | 1 | of 1 | | | 100% | | | |

Incident Report

Participant Data

Confirmation Numner	9		
Last Name	bestie	First Name	p
Gender	Female	DOB	1
Address	1724 Los Robles		
City	Fishers	State	IN
County	Hamilton	Zip	4
Funding Source	1915(i) CMHW Services		

Informed Data

Residential Provider	Date:	Legal Guardian	L
Wraparound Facilitator	Billy Madison **Date: 9/22/2014**	WF (Other):	
CPS	Date:	Coroner	D
Individual Supervising at Time of Incident: Sheldon Cooper			

Reporting Person & Agency

Last Name	Farrah-Fowler	First Name	A
Phone	(317) 254-2635	Email	S
Reporting Agency	GSW Test Provider 1 - 123456789A	If unable to specify:	
Was a provider present/involved at the time of incident? Unknown			

Incident Information

Date Incident Occurred	9/19/2014	Time Incident Occurred	
Incident Type	physical injury to right shoulder	Date of Knowledge	9
Date Report Submitted	9/29/2014	Late Submission Explanation (If applicable)	e

Save/Print Incident Report | **Report New Incident** | **Home**

To Save/Print your report select 'Save/Print Incident Report'

The following box will appear

- Open to print
- Save to place file to folder

Follow-Ups

Creating Follow-Ups

- To start a follow up select Follow-Up to Initial Incident Report

Fill out all necessary information in each section

- Identifying Data
- Follow-Up Narrative
- Reporting Information

Identifying Information

Required information:

- Incident Number
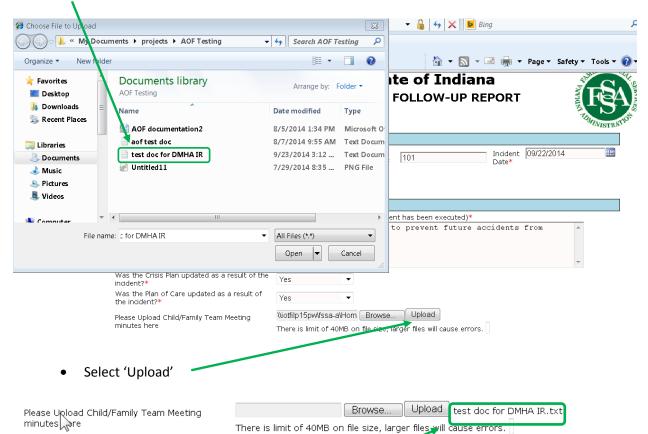- Incident Date
- First & Last Name

Follow-Up Narrative

Required information:

- Follow-Up to Incident
- Crisis Plan updated
- Plan of Care updated

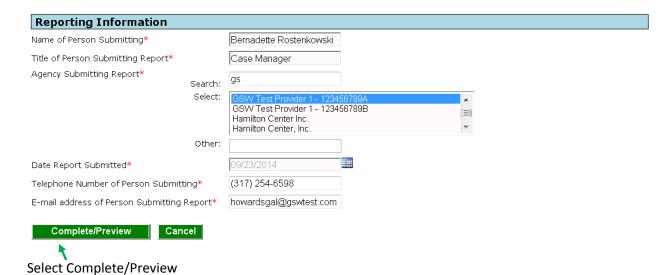Uploading documents

- Select 'Browse' button
- Choose file

- Select 'Upload'

The successful uploaded document will appear

Reporting Information

Required information:

- Name of person submitting
- Title
- Agency
- Date
- Telephone number
- Email address

Select Complete/Preview

If there is missing information or errors a warning message will appear

Submitting Follow-Up Reports

To Change/Edit any entries select the 'Edit Follow-Up Entries' button

DMHA – FOLLOW-UP REPORT

| Edit Follow-Up Entries |

Identifying Data

| Participant ID | | ID Type | | Incident Number* | 9 | Incident Date* | 09/19/2014 |
| Last Name* | Bestie | First Name* | | Penny |

Follow-Up Narrative

Follow-Up to Incident (Please explain how the Plan to Resolve from the Initial Incident has been executed):
enter follow up information in this box

Was the Crisis Plan updated as a result of the incident?	Yes
Was the Plan of Care updated as a result of the incident?	Yes
Please Upload Child/Family Team Meeting minutes here	test doc for DMHA IR.txt

Reporting Information

Name of Person Submitting*	Bernadette Rostenkowski
Title of Person Submitting Report*	Case Manager
Agency Submitting Report*	GSW Test Provider 1 - 123456789A
	Other:
Date Report Submitted*	09/30/2014
Telephone Number of Person Submitting*	(317) 254-6598
E-mail address of Person Submitting Report*	howardsgal@gswtest.com

| Submit Form | | Cancel |

Once the errors have been corrected, select 'Submit Form'

Saving/Printing Follow- Up Reports

After your report is submitted the following screen will appear showing two important things

- Confirmation number
- Successfully submitted message

Follow-Up Report has been successfully submitted. Confirmation Number:20

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Follow-Up Report

Identifying Data	
Confirmation Number	21
Participant ID	
Paticipant ID Type	
Name	Bestie, Penny
Incident Number	9
Incident Date	9/19/2014

Follow-Up Narrative	
Follow-Up to Incident	enter follow-up information in this box
Was the Crisis Plan updated as a result of the Incident?	True
Was the Plan of Care updated as a result of the incident?	True

Reporting Information	
Name of Person Submitting	Bernadette Rostenkowski
Title of Person Submitting	Case Manager
Agency Submitting Report	GSW Test Provider 1 - 123456789A **Other:**
Date Report Submitted	9/30/2014
Telephone Number of Person Submitting	(317) 254-6598
Email Address of Person Submitting Report	howardsgal@gswtest.com

Save/Print Follow-Up Report	Report New Follow-Up	Home

To Save/Print your report select 'Save/Print Follow-Up Report'

The following box will appear

- Open to Print
- Save to place file in folder

Complaint Reports

Creating A Complaint Report

- Start a report by selecting Complaint Report from the menu

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Fill out the necessary information in the following sections

- Contact Information
- Program, Participant and Provider
- Description of Grievance or Complaint
- Additional Information

Contact Information

Contact Information

Optional Contact Information
If you want DMHA to discuss the concern/complaint with you, please provide contact information and preferred method of contact:

Name of Person Completing Form	Mary Cooper	
Phone	(260) 412-3520	☑ Preferred Method of Contact
Email	sheldonsmom@gmail.cor	☐ Preferred Method of Contact

Program, Participant and Provider

Required information:

- Service program

Program, Participant, and Provider

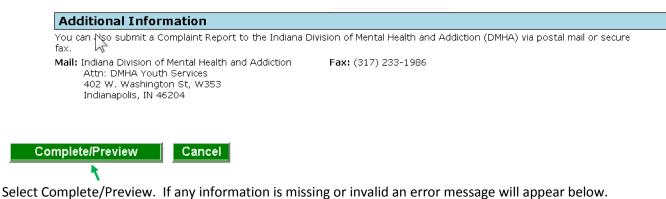|	
Service Program In which program is the Participant enrolled?*	1915(i) CMHW Services ▼
Name of Participant (Optional)	Sheldon Cooper
Name of Provider	

Description of Grievance or Complaint

Required information:

- Grievance or complaint
- Date complaint occurred

Description of Grievance or Complaint

Grievance or Complaint
Please describe the complaint or issue. Include details such as persons, services and dates involved, as applicable.*

test entry

Date Complaint Occurred*   09/23/2014

Additional information is listed in a section below with instructions on sending a complaint via postal mail or secure fax.

Additional Information

You can also submit a Complaint Report to the Indiana Division of Mental Health and Addiction (DMHA) via postal mail or secure fax.

Mail: Indiana Division of Mental Health and Addiction   **Fax:** (317) 233-1986
          Attn: DMHA Youth Services
          402 W. Washington St, W353
          Indianapolis, IN 46204

Complete/Preview   **Cancel**

Select Complete/Preview. If any information is missing or invalid an error message will appear below.

The following fields are required:

- Service Program
- Grievance/Complaint
- Date Complaint Occurred

Submitting Complaint Reports

To edit select 'Edit Complaint Entries'

DMHA – COMPLAINT REPORT

Edit Complaint Entries

Contact Information

Optional Contact Information
If you want DMHA to discuss the concern/complaint with you, please provide contact information and preferred method of contact:

Name of Person Completing Form   Mary Cooper

Phone   (260) 412-3520   ☑ Preferred Method of Contact

Email   Sheldonsmom@gmail.com   ☐ Preferred Method of Contact

Program, Participant, and Program

Service Program
In which program is the Participant enrolled? *   1915(i) CMHW Services

Name of Participant (Optional)   Sheldon Cooper

Name of Provider

Description of Grievance or Complaint

Grievance or Complaint
Please describe the complaint or issue. Include details such as persons, services and dates involved, as applicable. *

test entry complaint

Date Complaint Occurred *   09/23/2014

Additional Information

You can also submit a Complaint Report to the Indiana Division of Mental Health and Addiction (DMHA) via postal mail or secure fax.

Mail: Indiana Division of Mental Health and Addiction   **Fax:** (317) 233-1986
     Attn: DMHA Youth Services
     402 W. Washington St, W353
     Indianapolis, IN 46204

Submit Form   Cancel
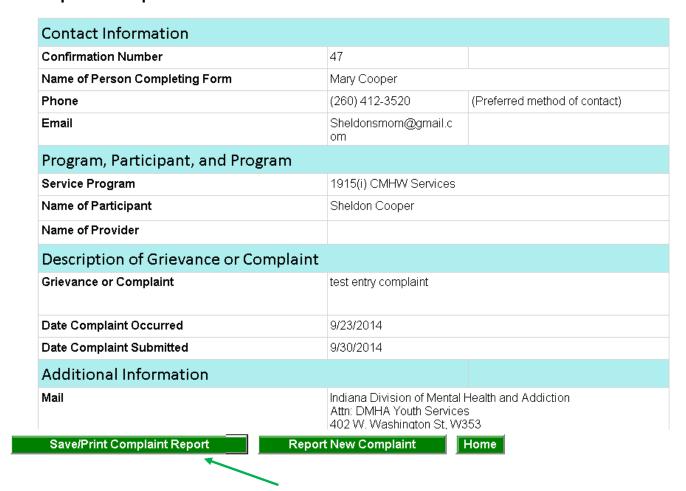
Once corrected select 'Submit Form'

Saving/Printing Complaint Reports

After your report is submitted the following screen will appear showing two important things

- Confirmation number
- Successfully submitted message

Complaints report has been successfully submitted. Confirmation number: 46

◄◄	◄	1	of	1	►	►►	⇐	100%	▼	💾▼	🖨

Complaint Report

Contact Information

Confirmation Number	47	
Name of Person Completing Form	Mary Cooper	
Phone	(260) 412-3520	(Preferred method of contact)
Email	Sheldonsmom@gmail.com	

Program, Participant, and Program

Service Program	1915(i) CMHW Services
Name of Participant	Sheldon Cooper
Name of Provider	

Description of Grievance or Complaint

Grievance or Complaint	test entry complaint
Date Complaint Occurred	9/23/2014
Date Complaint Submitted	9/30/2014

Additional Information

Mail	Indiana Division of Mental Health and Addiction Attn: DMHA Youth Services 402 W. Washington St, W353

Save/Print Complaint Report	Report New Complaint	Home

To Save/Print your report select 'Save/Print Complaint Report'

The following box will appear

- Open to Print
- Save to place file in folder