

Imagine Support Services, LLC

Incident Report

Individual's Name (Last, First, M.I.)	ASSIST ID:	D.O.B.
Provider Agency @ Time of Incident Imagine Support Services, LLC	Foster Care (Yes, No):	Guardian:
Individual's Address:	Location of the Incident:	Incident Date & Time:
Staff/Witness:	Phone No.:	Supervisor:
Staff/Witness:	Phone No.:	Supervisor:

What happened prior to the incident?

What happened during the incident?

What happened after the incident?

What, if anything, could have prevented the incident?

What steps are being taken to ensure that the incident is not repeated?

Describe any medical interventions. Include addresses and phone numbers of medical facilities involved.

Entity	Notified (Yes, No)	Name of Person Notified	Notified by Whom?	Date/Time of Notification
Parent/Guardian				
DDD Support Coordinator				
CPS/APS				
Law Enforcement				
Other				

Name & Title of Person Completing this Form:

Signature: _____ Date: _____

Client File: _____

DDD Secure Email: (DDDWestIR@azdes.gov) _____

For questions and/or follow-up to this incident report, contact Imagine Support Services, LLC at (623) 271-8014 or via email at dj@isscare.com.