VA New York / New Jersey Health Care Network
HCHV Contract Residential Care Program
Incident Report

(To be completed and faxed to the VA GPD Liaison within 24 hours of an incident occurring.)

Name of Veteran:

Social Security No.:

Agency / Facility:

Contract No.:

Description of the Incident

Date of Incident: **Time of Incident:**

Location of Incident:

Type of Incident:

- ☐ Death (N)
- ☐ Fire (N)
- ☐ Drug / Police Raid (N)
- ☐ Suicide / Suicide Attempt
- ☐ 911 Call (Police / Fire Dept. / Paramedics / Other)
- ☐ Severe Medical Illness / Emergency
- ☐ Severe Psychiatric Illness / Emergency
- ☐ Sexual Assault
- ☐ Act of violence by veteran against other resident(s) or staff
- ☐ Abusive behavior by veteran against staff
- ☐ Act of violence by other resident(s) or staff against veteran
- ☐ Abusive behavior by staff against veteran
- ☐ Accident (Specify: _____)
- ☐ Medication Problem:
  - ☐ Medication not sent
  - ☐ Incorrect medication sent
  - ☐ Missing medications
  - ☐ Adverse drug reaction
- ☐ Other (Specify: _____)

(N) = National report required

(Please continue report on next page)

Brief Description of the Incident ***(please include circumstances leading up to the incident, names of witnesses, if any, and outcomes; attach additional pages as needed):***

Action(s) taken by Contract Provider:

Name of VA Staff Contacted:

Report Completed By:

Title: **Date:**

Signature:

Phone: **Email:**

For VA HCHV Contract Residential Care Liaison

Additional information and actions taken including date(s):

Report filed:

☐ **Nationally** **Sent to: _____**

Date: _____

☐ **Locally** **Sent to: _____**

Date: _____

Follow Up Required (if any):

VA Liaison: _____

Signature: _____ **Date: _____**