West Virginia Medicaid Aged & Disabled Waiver Program
PERSONAL OPTIONS INCIDENT REPORT
Confidential

Incident Date: _____
Time: _____a.m./p.m.

***SECTION I* – Member Information (completed by person reporting incident)**

LAST:	FIRST:

ADDRESS: CITY: STATE: ZIP:

COUNTY: DOB: GENDER: □ M □ F

***SECTION II*– Description of Incident (completed & signed by person reporting incident)**

Describe in detail the reportable incident including other persons involved. Attach additional page(s) if necessary.

When was the Resource Consultant Notified? Date: _____ Time: _____
Resource Consultant's Name:_____
Signature of Person Reporting Incident: _____ Date: _____

If allegation of abuse, neglect or exploitation, incident must be reported to APS at: (800) 352-6513