

**Traumatic Brain Injury Waiver Program
PERSONAL OPTIONS INCIDENT REPORT
Confidential**

Incident Date: _____
Time: _____ a.m./p.m.
Type of Incident: Critical Simple

Abuse Neglect Exploitation

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

