

House of New Hope
CRITICAL INCIDENT REPORT – FOSTER CARE

IMPORTANT: This report must be received by HONH within 24-hours of the incident. Failure to meet this deadline will result in a rule violation. Send by FAX to: 740-745-3429 or send by EMAIL: criticalincident@houseofnewhope.org

----ONLY 1 INCIDENT AND 1 CLIENT PER FORM----

Date Incident was reported to HONH: _____ Time Incident was reported to HONH: _____ AM ___ PM ___

Name of person reporting this incident: _____

Reporter’s Email: _____ Reporter’s Contact Number: _____

Primary child this incident refers to: Name _____ Birth date: _____ Age ___

County Agency _____ County Caseworker _____

HONH Clinician _____

Date of Incident: _____ Time of Incident: _____ AM ___ PM ___ Exact Time/Date is unknown _____

Incident location type: _____ foster/adoptive home _____ school _____ community location _____ other

Incident location name: _____ Incident location telephone: _____

Incident location address: _____

**** = Need for immediate Notification to HONH (see Foster Parent Notification Requirements below)**

Not critical, but important enough to document and share.

CRITICAL INCIDENT TYPE - check all that apply for this incident

<input type="checkbox"/> Aggression <input type="checkbox"/> Physical Assault <input type="checkbox"/> Sexual Assault <input type="checkbox"/> AWOL** <input type="checkbox"/> AWOL return <input type="checkbox"/> Criminal /Delinquent Activity <input type="checkbox"/> Death of a Client** <input type="checkbox"/> Explicit Threat <input type="checkbox"/> Harm to Self <input type="checkbox"/> Harm to Others <input type="checkbox"/> Fire Setting <input type="checkbox"/> Injury to Client <input type="checkbox"/> Injury to Other Caused by Client <input type="checkbox"/> Loss, Damage, or Theft	<input type="checkbox"/> Medical Treatment ** <input type="checkbox"/> First Aid <input type="checkbox"/> Emergency Room <input type="checkbox"/> Admitted to Hospital <input type="checkbox"/> Medication Concern <input type="checkbox"/> Missed Meds <input type="checkbox"/> Refusal to Take <input type="checkbox"/> Change in Medication <input type="checkbox"/> Placement Disruption due to Fire, Disaster, etc.** <input type="checkbox"/> Police/Sheriff involvement** <input type="checkbox"/> Racial Incident Involving Client	<input type="checkbox"/> Restraint Used on Client** <input type="checkbox"/> School discipline of Client <input type="checkbox"/> School expulsion <input type="checkbox"/> School suspension <input type="checkbox"/> Self-Injury Inflicted by Client <input type="checkbox"/> Self-Injury <input type="checkbox"/> Self-Mutilation <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Substance abuse/possession <input type="checkbox"/> Suspected Abuse or Neglect <input type="checkbox"/> Vehicle Accident or Violation <input type="checkbox"/> Victim of a crime <input type="checkbox"/> Weapon possession/use
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Foster Parent Notification Requirements

Must notify HONH within 1 hour of the caregiver gaining knowledge of any of the following circumstances involving a foster child:

- **A serious injury or illness involving medical treatment of a foster child**
- **The death of a foster child**
- **AWOL**
- **Removal or attempts to remove a foster child from the home by any person or agency other than HONH**
- **Any involvement of a foster child with law enforcement**
- **Police or sheriff involvement**
- **Use of Restraint / Bear Hug.**

Must notify HONH within 24 hours or the next business day when any fire requiring the services of a fire department occurs within the home.

Must notify HONH and the placing agency within 24 hours when the foster home becomes uninhabitable for any reason

Must notify HONH in writing of any person residing for more than two weeks in the foster home

List all persons who provided professional medical treatment (if applicable):

Name	Contact Number

List additional people involved in the incident (if applicable):

Name	Age	Contact Number

Who observed the incident? _____

Who told you about the incident? _____

What happened? (Please be very specific as to whom, what, where, when and why): *Add paper if necessary*

What do you think lead up to or caused the incident?

What was done immediately following the incident? (Please be specific; if injury, describe how treated):

What needs to be done to keep client/everyone safe at this point? (Safety plan):

If a Restraint / Bear Hug was used:

1. Was verbal de-escalation attempted prior to using a physical restraint? YES _____ NO _____
2. Is the client under 80 pounds? YES _____ NO _____
3. How many minutes was the child held in the Bear Hug? _____
4. Did you sit with the client after the restraint and have a discussion about the incident? YES _____ NO _____

Who was notified by you?

Name	Agency	Date and Time

-HONH STAFF USE-

SACWIS Person ID#: _____	
Reported to: _____ CSB CW _____ CSB Intake/Hotline _____ Other	
Clinical Staff: _____	
Date: _____	
Clinical Supervisor: _____	
Date: _____	
Executive Director (major only): _____	Date: _____
Follow Up Required? _____ NO _____ YES Note: _____	