



Division of Technology Services
DEVELOPMENT AND APPLICATION SUPPORT

DDRS Incident and Follow-Up Reporting (IFUR) Tool

User Guide

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1. The DDRS Incident and Follow-Up Reporting (IFUR) Tool

The DDRS Incident and Follow-Up Reporting (IFUR) tool is a web-based software program that you can use to:

- Complete and submit an electronic report about an incident that occurred with a developmentally disabled consumer.
- Complete and submit an electronic follow-up report about an incident.
- Print a hard copy of an incident or follow-up report to complete by hand.

1.1. *Product Support*

If you encounter a problem with this product, or if you have a question or recommendation regarding this user guide, send an email to the Development and Application Support (DAS) team at DTS-DAS@fssa.in.gov. A member of the DAS Help Desk team will contact you to address the issue.

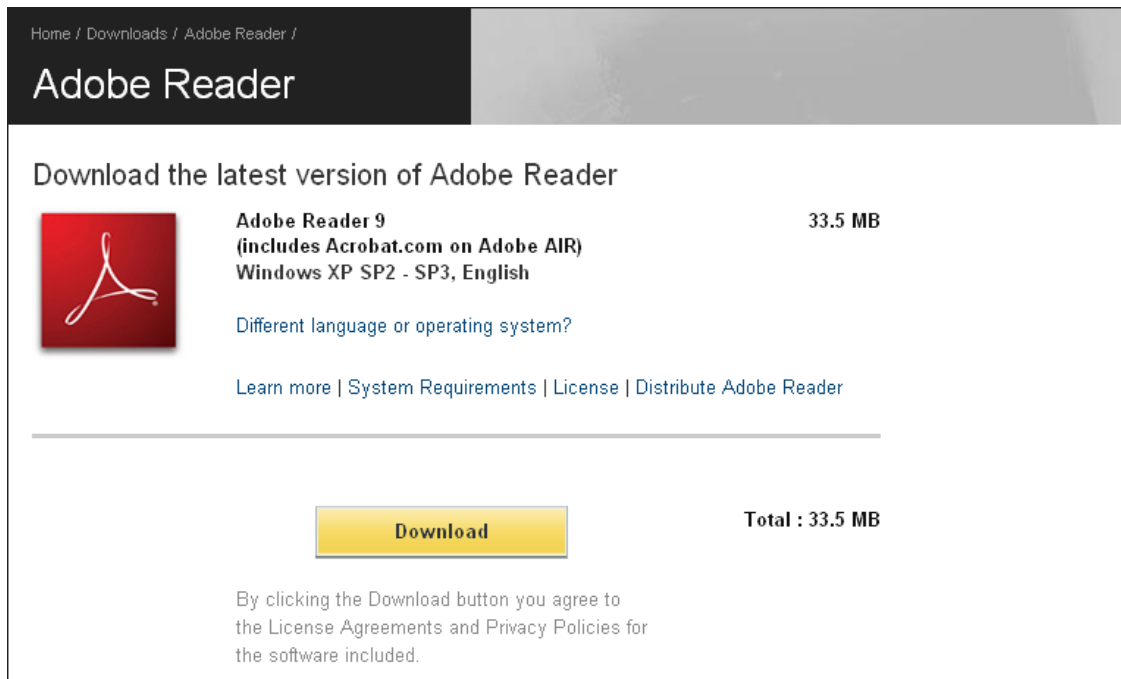
1.2. *Installing and Testing the Latest Version of Adobe Reader*

Some of the features available in the IFUR tool require that you install the Adobe Reader add-on software to enhance the system's performance. The Adobe Reader is required for saving and printing incident and follow-up reports. Use the following section for installing and testing the latest version of Adobe Reader on your computer (the procedure assumes that you have not installed the Adobe DLM ActiveX control).

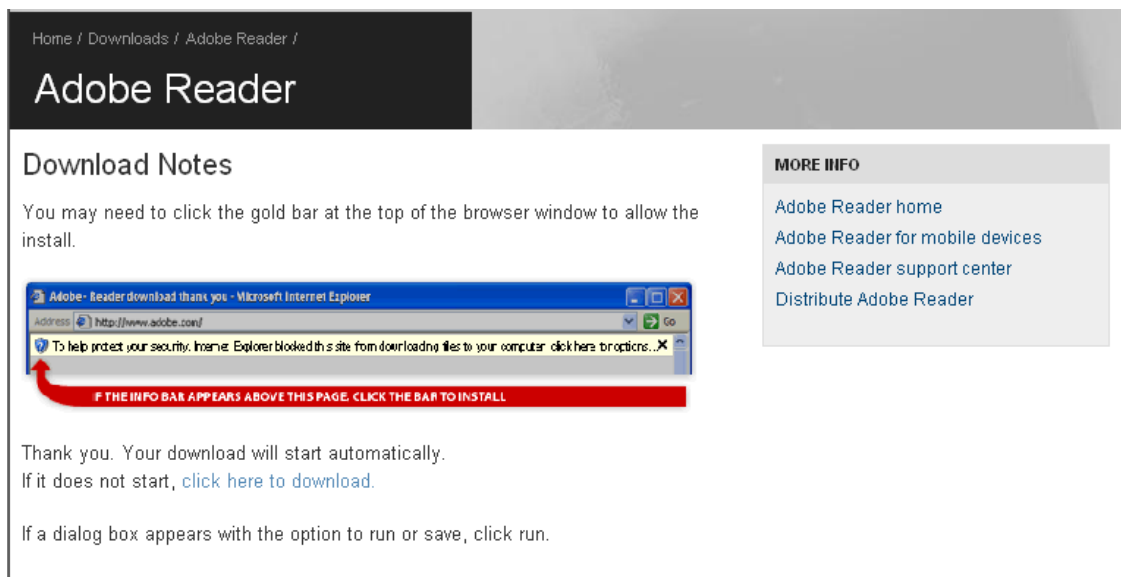
1. Select the following link or enter the URL into the **Address** field of your browser:

<http://www.adobe.com/products/acrobat/readstep2.html>

The Adobe Reader web page appears, as shown in the following illustration:



2. Select the gold **Download** button. The system displays the following screen and a gold bar appears at the top of your browser window:



3. Select **Click here to install** from the gold bar at the top of the browser window, and then select **Install ActiveX Control** from the shortcut menu that appears.
4. Select **Install** in the **Internet Explorer - Security Warning** window that appears.

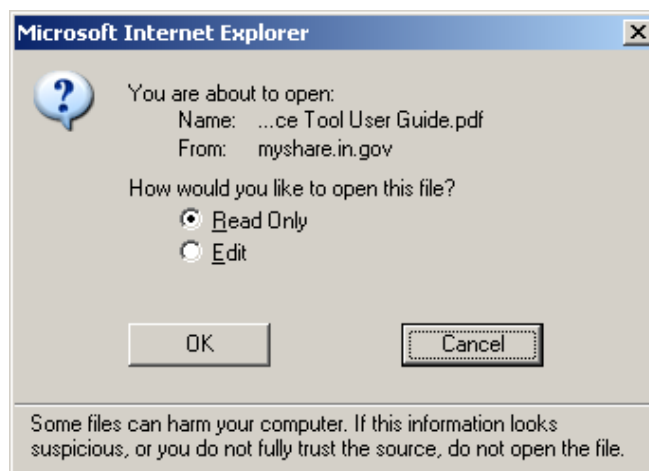
5. Wait several seconds as one or more Adobe progress windows appear, indicating the progress of the installation. When the installation is complete, the **getPlus: Info** window appears and indicates that the installation is complete.
6. Select **OK** in the **getPlus: Info** window.
7. Test the Adobe Reader installation by selecting a PDF file from either the network or a SharePoint site.

Tip

Select the following link to display a SharePoint page that contains multiple PDF files that you can use:

<https://myshare.in.gov/FSSA/ddrs/WebBased%20Tools/Forms/AllItems.aspx>

8. Ensure that the **Read Only** radio button is selected in the **Microsoft Internet Explorer** window that appears and then select **OK**. The following illustration shows an example of the **Microsoft Internet Explorer** window:



Because this is the first PDF you have opened after installing the Adobe Reader, the **Adobe Reader – License Agreement** window appears, as shown in the following illustration:



9. Select **Accept** to display the PDF file for the document you selected.

The **Adobe Reader – License Agreement** window appears only once. After you perform the remaining steps in this procedure, the license agreement will not appear again when you select a PDF file.

1.3. Accessing the IFUR Tool

To access the IFUR tool, select the following link or manually enter the URL into your browser's **Address** field:

<https://ddrsprovider.fssa.in.gov/ifur/>

The IFUR tool home page appears, as shown in the following illustration:

State of Indiana
Division of Disability and Rehabilitative Services
INCIDENT AND FOLLOW-UP REPORTING TOOL

Home
[Provider Tools](#)
[User Guide](#)

Menu
[Incident Initial](#)
[Incident Follow-Up](#)
[Incident Forms](#)

Welcome to the BQIS/DA Web-Based Incident And Follow-Up Reporting Tool

NOTICE TO USERS: This website is for filing incident initial and incident follow-up reports required by the Indiana Bureau of Quality Improvement Services and the Indiana Division of Aging waiver services, including MFP. Based on the 'Primary Funding Source' that is selected, only fields that apply to the appropriate division will be enabled to be filled in.

Please be aware that changes have recently been made to the site. If you are reporting the death of an individual or a PRN medication administration, you can only submit the report for a single individual. Other changes are minor but appear throughout the application.

This site is maintained by the Division of Disability and Rehabilitative Services. Please report any problems with the website by sending an e-mail to DDRSdata@fssa.in.gov.

Tip

Read the **Notice to Users** in the Welcome section of the IFUR tool home page to become familiar with some of the changes that have recently occurred with the IFUR tool.

The IFUR tool uses a dynamic menu structure on the left side of the screen that shows or hides menus as you move through the system. You can use one or more of the following menu items:

Home	To return to the IFUR tool home page
Provider Tools	To access the DDRS Web-Based Tools page
User Guide	To access this user guide
Incident Initial	To start an Incident Initial Report
Incident Follow-Up	To start an Incident Follow-Up Report
Incident Forms	To print blank PDF copies of the Incident Initial and Incident Follow-Up Reports

2. Completing an Incident Initial Report

To complete an **Incident Initial Report**, select **Incident Initial** from the menu structure. The **Consumer Information** section of the **Incident Initial Report** appears and displays fields that you can use to add demographic information about the consumer. The following illustration shows an example of a completed **Consumer Information** section:

Consumer(s):			
Consumer Information			
Social Security Number:	<input type="text" value="123-45-6789"/>		
First Name:	<input type="text" value="John"/>	Last Name:	<input type="text" value="Public"/>
Address:	<input type="text" value="1200 E. Main St."/>		City:
	<input type="text" value="Muncie"/>		
State:	<input type="text" value="IN"/>	Zip code:	<input type="text" value="47304"/>
DOB:	<input type="text" value="02/25/1980"/>	County:	<input type="text" value="DELAWARE"/>
Gender:	<input type="text" value="M"/>		
Primary Funding Source:	<input type="text" value="DD WVR"/>		
<input type="button" value="Remove This Consumer"/> <input type="button" value="Add Additional Consumer"/> <input type="button" value="Cancel Report"/> <input type="button" value="Continue Report"/>			

2.1 Required Fields

The **Incident Initial Report** and **Incident Follow-Up Report** contain several fields that require an entry. If you select the **Continue Report** button to move to the next page and have not completed one or more required fields, the system displays a message in red text at the top of the page and marks each required field with a red asterisk. You must complete the missing fields before the system will move to the next page.

All of the fields in the **Consumer Information** section of the **Incident Initial Report** are required.

2.2 Informed Section

After you select a funding source from the **Primary Funding Source** field, the system displays the **Informed** section of the **Incident Initial Report**. This section of the report disables the fields that are not required, based on the funding source that you selected. Disabled fields appear gray in color, as shown in the following illustration of the DD WVR funding source fields:

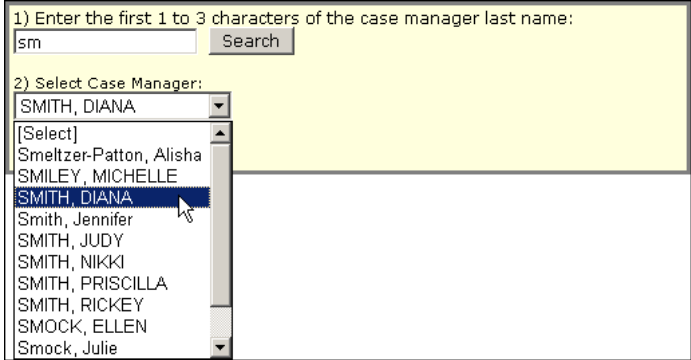
Informed	
Indicate which of the following agencies and individuals have been informed:	
APS: <input type="text" value="N/A"/>	Name: <input type="text"/>
	Date: <input type="text"/>
	County: <input type="text" value="[Select]"/>
	Phone: <input type="text" value="() - -"/>
	Method: <input type="text" value="[Select]"/>
CPS: <input type="text" value="N/A"/>	Name: <input type="text"/>
	Date: <input type="text"/>
	County: <input type="text"/>
	Phone: <input type="text" value="() - -"/>
	Method: <input type="text" value="[Select]"/>
RES. Provider(BDDS): <input type="text" value="N/A"/>	
HCBS Provider(DA): <input type="text" value="N/A"/>	
HAB/VOC Provider(BDDS): <input type="text" value="N/A"/>	
Other Provider: <input type="text" value="N/A"/>	
Legal guardian: <input type="text" value="N/A"/>	Name: <input type="text"/>
	Date: <input type="text"/>
BDDS SC(BDDS):	<input type="text" value="Select"/>
	Date: <input type="text"/>
AAA(DA): <input type="text" value="N/A"/>	<input type="text" value="Select"/>
	Date: <input type="text"/>
Case Manager: <input type="text" value="YES"/>	<input type="text" value="Select"/>
	Date: <input type="text"/>
QMRP: <input type="text" value="N/A"/>	Name: <input type="text"/>
	Date: <input type="text"/>
Police: <input type="text" value="N/A"/>	Date: <input type="text"/>
Coroner: <input type="text" value="N/A"/>	Name: <input type="text"/>
	Date: <input type="text"/>
Individual supervising at time of incident(BDDS): <input type="text"/>	
Responsible Supervisory provider(BDDS): <input type="text" value="Select"/>	
Individual providing services at time of incident(DA): <input type="text"/>	
HCBS provider agency(DA): <input type="text" value="Select"/>	
<input type="button" value="Remove This Consumer"/> <input type="button" value="Add Additional Consumer"/> <input type="button" value="Cancel Report"/> <input type="button" value="Continue Report"/>	

2.3 Contingency Fields

The requirement for some fields is contingent on other selections. For example, if you select a waiver funding source from the **Primary Funding Source** field in the **Consumer Information** section, you must complete the **Case Manager, Name,** and **Date** fields in the **Informed** section.

The following table describes the contingency fields in the **Informed** section of the **Incident Initial Report**.

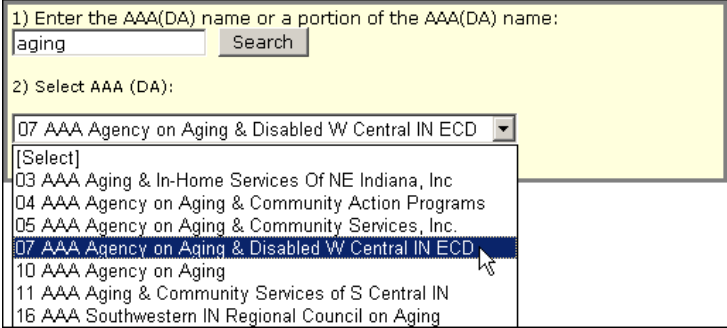
Contingency Fields for Consumer Information and Informed Sections

If this Field	Contains	Then
<p>Primary Funding Source</p> <p>Refer to the Primary Funding Source table for information about all of the fields affected by an entry in this field.</p>	<p>One of the following entries:</p> <p>A&D WAIVER AUTISM WVR DD WVR SUP SER WVR TBI WAIVER</p>	<p>Case Manager field contains Yes.</p> <p>You must select the Case Manager and complete the corresponding Date field.</p> <p>To select the Case Manager, click the Select button. A search window appears. Enter the first 1 to 3 characters of the Case Manager's last name in the text box and select Search. The system uses the entry to populate the drop down list in the Select Case Manager field, as shown in the following illustration:</p>  <p>Important</p> <p>If you are searching for a name with a space or a period, you must include the space or period. For example, to search for St. James, enter st. and include the period.</p> <p>Select a case manager name from the list and then select the Submit button.</p>
<p>Primary Funding Source</p>	<p>SGL</p>	<p>QMRP field must contain Yes.</p>

Contingency Fields for Consumer Information and Informed Sections (continued)

If this Field	Contains	Then
Primary Funding Source	One of the following entries: A&D WAIVER TBI WAIVER	The following BDDS fields must contain N/A or be left blank: <ul style="list-style-type: none"> • RES. Provider(BDDS) • HAB/VOC Provider(BDDS) • BDDS SC(BDDS) Name • BDDS SC(BDDS) Date • Individual supervising at time of incident(BDDS) • Responsible Supervisory provider (BDDS)
Primary Funding Source	One of the following entries: AFC AUTISM WVR CFC DD WVR LP-ICF/MR NURSING HOME SDC/SOF SGL SLI RESIDENTIAL SUP SER WVR TITLE XX	You must select a Service Coordinator and complete the corresponding Date field. To select the Service Coordinator, click the Select button. A search window appears. Enter the first 1 to 3 characters of the Service Coordinator’s last name in the text box and select Search . The system uses the entry to populate the drop down list in the Select BDDS SC field, as shown in the following illustration: <div data-bbox="673 1039 1416 1283" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>1) Enter the first 1 to 3 characters of the SC(BDDS) last name: <input type="text" value="sm"/> <input type="button" value="Search"/></p> <p>2) Select BDDS SC: <input type="text" value="SMITH, DANE"/> [v] [Select] SMITH, CAROL SMITH, DANE SMITH, ROZINE</p> </div> <p>Important If you are searching for a name with a space or a period, you must include the space or period. For example, to search for St. James, enter st. and include the period.</p> <p>Select a Service Coordinator name from the list and then select the Submit button.</p> <p>The following aging fields must contain N/A or be left blank:</p> <ul style="list-style-type: none"> • HCBS Provider(Aging) • AAA(Aging) • Individual providing services at time of incident(Aging) • HCBS provider agency(Aging)

Contingency Fields for Consumer Information and Informed Sections (continued)

If this Field	Contains	Then
APS or CPS	Yes	The following APS/CPS fields must be completed: <ul style="list-style-type: none"> Name Date County Phone Method
Legal guardian	Yes	The following Legal guardian fields must be completed: <ul style="list-style-type: none"> Name Date
AAA(DA)	Yes	<p>You must select the AAA name and complete the AAA (DA) Date field.</p> <p>To select the AAA, click the Select button. A search window appears. Enter the AAA name or a portion of the AAA name in the text box and select Search. The system uses the entry to populate the drop down list in the Select AAA (DA) field, as shown in the following illustration:</p>  <p>Select a AAA name from the list and then select the Submit button.</p>
QMRP	Yes	The following QMRP fields must be completed: <ul style="list-style-type: none"> Name Date
Police	Yes	The Police Date field must be completed.
Coroner	Yes	The following Coroner fields must be completed: <ul style="list-style-type: none"> Name Date

The table displayed on the next page describes all of the fields affected by an entry in the **Primary Funding Source** field. To use the table, locate the funding source in the top row, and then read down to determine which fields require an entry.

LEDGEND		PRIMARY FUNDING SOURCE													
<input checked="" type="checkbox"/>	Required	ALL FIELDS NOT MARKED ARE OPTIONAL FIELDS													
<input type="checkbox"/>	Unavailable	A&D Waiver	AFC	AUTISM WAIVER	CFC	DD WAIVER	LP-IGF/MR	MFP	NURSING HOME	SDC/SOF	SGL	SU RESIDENT.	SUPER WAIVER	TBI WAIVER	TITLE XX
<input type="checkbox"/>	Optional														
APS/CPS															
If the option button is -	YES														
then fill-in the -	Date														
select the -	County														
fill-in the -	Phone														
and select the -	Method														
RES. Provider(BDDS)															
Yes		X						X						X	
HCBS Provider(DA)															
Yes			X	X	X	X	X		X	X	X	X	X		X
HAB/VOC Provider(BDDS)															
Yes		X						X						X	
Other Provider															
Yes															
Legal guardian															
If the option button is -	YES														
then fill-in -	Name														
and fill-in -	Date														
BDDS SC(BDDS)															
Click -	Select	X	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓
and fill-in -	Date														
AAA(DA)															
If the option button is -	YES														
click -	Select		X	X	X	X	X		X	X	X	X	X		X
and fill-in -	Date														
Case Manager															
If the option button is -	YES	✓		✓		✓		✓				✓	✓		
click -	Select														
and fill-in -	Date														
QMRP															
If the option button is -	YES	✓									✓				
then fill-in -	Name														
and fill-in -	Date														
Police															
If the option button is -	YES														
then fill-in -	Date														
Coroner															
If the option button is -	YES														
then fill-in -	Name														
and fill-in -	Date														
Individual Supervising at the Time of Incident (BDDS) Field															
Fill-in -		X	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓
Responsible Supervisory Provider (BDDS)															
Select -		X	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓
Individual Providing Services at the Time of Incident (DA)															
Fill-in -		✓	X	X	X	X	X	✓	X	X	X	X	X	✓	X
HCBC Provider Agency (DA)															
Select -		✓	X	X	X	X	X	✓	X	X	X	X	X	✓	X

2.4 Reporting Person / Agency and Incident Information

After you complete the fields in the **Consumer Information** and **Informed** sections, select the **Continue Report** button to move to the next page of the report. You can also use the additional buttons at the bottom of the page to remove the consumer, add another consumer, or cancel the report.

The **Reporting Person and Agency** and **Incident Information** sections appear, as shown in the following illustration:

Reporting Person and Agency			
Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Position:	<input type="text"/>		
Phone #:	(<input type="text"/>) <input type="text"/> - <input type="text"/>	Extension:	<input type="text"/>
Reporting Agency:	<input type="button" value="Select"/>		
Date of Report:	6/26/2009		
E-mail Address:	<input type="text"/>		
Incident Information			
Incident Date:	<input type="text"/>	Time (HH:MM AM/PM):	<input type="text"/>
Date of Knowledge:	<input type="text"/>		
Where occurred:	<input type="button" value="[Select]"/>		
Other(explain): <input type="text"/>			
Is this Incident regarding:			
the Death of this consumer? <input type="button" value="[Select]"/>			
a PRN that was administered to this consumer? (BDDS) <input type="button" value="[Select]"/>			
Were Police involved? <input type="button" value="NO"/>			
Was the consumer handcuffed? <input type="button" value="NO"/>			
Was the consumer tasered? <input type="button" value="NO"/>			
<input type="button" value="Cancel Report"/>		<input type="button" value="Continue Report"/>	

The following fields in the **Reporting Person and Agency** section are required:

- Name
- Position
- Phone #
- Reporting Agency
- E-mail Address
- Incident Date
- Date of Knowledge
- Where occurred
- ...regarding the Death of Consumer?
- ...regarding a PRN administered?

The following fields in the **Incident Information** section are required:

- **Incident Date**
- **Where occurred**

The following table describes the contingency fields in the **Incident Information** section:

Contingency Fields in the Incident Information Section

If this Field	Contains	Then
Primary Funding Source (in the Consumer Information section)	A&D WAIVER TBI WAIVER	The field labeled a PRN that was administered to this consumer? (BDDS) must contain No .
Where occurred	Other	You must complete the Other (explain) field.
Death of the consumer?	Yes	You must complete all of the questions in the Narrative: Details – DEATH section (see Section 2.4 – Narrative Information). Important If you complete an incident report for more than one incident, this field becomes unavailable. The system is designed to accept only one DOP incident per report.
PRN that was administered to this consumer?	Yes	You must complete all of the questions in the Narrative: Details – PRN section (see Section 2.4 – Narrative Information). Important If you complete an incident report for more than one incident, this field becomes unavailable. The system is designed to accept only one PRN incident per report.

2.5 Narrative Information

After you complete the information in the **Reporting Person and Agency** and **Incident Information** sections, select **Continue Report** to move to the next page of the report. The **Describe the Incident** and **Plan to Resolve** fields appear, as shown in the following illustration:

The screenshot shows a web form with two main sections. The first section is titled "Describe the Incident:" and contains a large, empty text input field. The second section is titled "Plan to Resolve (immediate and long term):" and also contains a large, empty text input field. At the bottom of the form, there are three buttons: "Cancel Report", "Edit Incident Information", and "Preview Report".

If you entered **YES** in the **Is this Incident regarding the Death of this consumer** field in the **Incident Information** section, then the **Narrative: Details – DEATH** section appears above the **Describe the Incident** and **Plan to Resolve** fields, as shown in the following illustration:

Narrative: Details - DEATH	
1. Date of Death:	<input type="text" value="___/___/___"/>
	Time Of Death (HH:MM AM/PM): <input type="text" value=""/>
2. Place Of Death:	<input type="text" value="[Select]"/>
	Other Setting (please explain): <input type="text" value=""/>
3. What was the setting if in NF less than 90 days:	<input type="text" value=""/>
4. Circumstances immediately preceding the death, IF KNOWN:	<input type="text" value=""/>
5. Circumstances immediately following the death or discovery of the death, IF KNOWN:	<input type="text" value=""/>
6. Describe all life-saving measures, IF ANY WERE APPLICABLE, that were attempted at the time of death (i.e., CPR administered, 911 called, transported to hospital, etc.), IF KNOWN:	<input type="text" value=""/>
7. If no life-saving measures were taken, please explain why not (i.e., was there a no-code status, do not resuscitate (DNR) order, etc.), IF KNOWN:	<input type="text" value=""/>
8. Was the individual admitted into a nursing facility within 30 days of the date of death?	<input type="text" value="[Select]"/>
9. Was the individual discharged from a nursing facility within 30 days of the date of death?	<input type="text" value="[Select]"/>
10. Was the death of the individual expected?	<input type="text" value="[Select]"/>
11. Was there a DNR status?	<input type="text" value="[Select]"/>
12. What is the preliminary cause of death?	<input type="text" value=""/>
13. Description of the event(s) surrounding this death is as follows:	<input type="text" value="[Select]"/>
	Other Circumstance(s) (please explain): <input type="text" value=""/>
Describe the Incident:	
	<input type="text" value=""/>
Plan to Resolve (immediate and long term):	
	<input type="text" value=""/>
<input type="button" value="Cancel Report"/> <input type="button" value="Edit Incident Information"/> <input type="button" value="Preview Report"/>	

If you entered **YES** in the **Is this Incident regarding a PRN that was administered to this consumer** field in the **Incident Information** section, then the **Narrative: Details – PRN** section appears above the **Describe the Incident** and **Plan to Resolve** fields, as shown in the following illustration:

Narrative: Details - PRN	
1. Length of time the targeted behavior lasted:	<input type="text"/>
2. Description of what precipitated the targeted behavior:	
	<input type="text"/>
3. Description of what efforts and/or activities were used and/or attempted to stop the behavior prior to the use of the PRN. For PRN's used before medical / dental procedures, description of the desensitization plan that is in place. Please Note: Even when a PRN has been approved by the guardian, physician, Human Rights Committee, IDT, etc., and/or is in the consumer's BSP, this information is still mandatory to process this incident initial report.	
	<input type="text"/>
4. State the criteria for the use of a PRN:	
	<input type="text"/>
5. PRN protocol (notification process, approval process, name and title of staff approving what medication and dosage):	
	<input type="text"/>
6. Date / Time of prior PRN:	<input type="text"/>
Describe the Incident:	
	<input type="text"/>
Plan to Resolve:	
	<input type="text"/>
<input type="button" value="Cancel Report"/> <input type="button" value="Edit Incident Information"/> <input type="button" value="Preview Report"/>	

If you entered **YES** in both of the **Is this Incident regarding...** fields in the **Incident Information** section, then both of the **Narrative: Details** sections appear above the **Describe the Incident** and **Plan to Resolve** fields.

2.6 Incident Initial Report Preview

After you have completed the fields in the **Incident Narrative** sections, select **Preview Report** to move to the next page of the report. The **Incident Initial Report** appears, as shown in the following partial illustration:

Cancel Report		Edit Incident Narrative		Submit Incident Initial Report	
1 of 2		100%			
Bureau of Developmental Disabilities		INCIDENT INITIAL REPORT - Confidential		REV 05-30-2008	
For Use in Reporting Circumstances in 460 IAC 1.2-8-2 and/or DA Policy and Procedure					
SECTION I - CONSUMER INFORMATION (Subject #1)					
SSN: ***-**-6789	LAST NAME: Public	FIRST NAME: John			
ADDRESS: 1200 W. Main St.	CITY: Muncie	STATE: IN	ZIP: 47034		
DOB: 2/25/1980	COUNTY: DELAWARE	GENDER: M			
PRIMARY FUNDING SOURCE: AUTISM WVR					
INDICATE WHICH OF THE FOLLOWING AGENCIES AND INDIVIDUALS HAVE BEEN INFORMED:					
HCBS PROVIDER?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> N/A	LEGAL GUARDIAN?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> N/A	NAME	DATE
		AAA?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> N/A	NAME	DATE
OTHER PROVIDER?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> N/A	CASE MANAGER?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> N/A	NAME	DATE
				ALDERSON, MARGARET	7/1/2008
		QMRP?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> N/A	NAME	DATE
		APS/CPS?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> N/A	NAME	DATE
		COUNTY	PHONE () - -	METHOD	
		CORONER?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> N/A	NAME	DATE
		POLICE?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> N/A	NAME	DATE
HCBS PROVIDER INFORMATION (providing Services at the time of incident, if applicable)					
HCBS PROVIDER AGENCY:		INDIVIDUAL PROVIDING SERVICES AT THE TIME OF INCIDENT:			
SECTION II - This section is intentionally blank					
SECTION III - REPORTING PERSON and REPORTING AGENCY					
LAST NAME:	FIRST NAME:	POSITION:	PHONE:	EXTENSION:	

2.7 Submitting, Saving, and Printing an Incident Initial Report

After you review the completed **Incident Initial Report** for accuracy and completeness, select the **Submit Incident Initial Report** button above the **Incident Initial Report Preview** page. You can also use the buttons above the report to cancel the **Incident Initial Report** or edit the incident information.

When you select the **Submit Incident Initial Report** button, the system displays:

- A message indicating that the report(s) were submitted to the DDRS/DA Central Office
- The confirmation number(s) for the report(s)
- A reminder to print or save a hard copy of the report(s)
- A **Save/Print** button

The following partial illustration shows the messages that appear when you submit an **Incident Initial Report**:



State of Indiana

Division of Disability and Rehabilitative Services

INCIDENT INITIAL REPORT



[Home](#)

[User Guide](#)

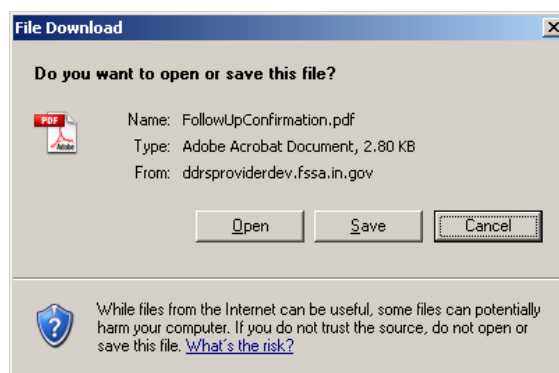
Incident Initial Report has been **SUCCESSFULLY** submitted to the DDRS/DA Central Office. Confirmation Number(s): 102128.

Remember to either save or print this report so that you can provide copies to other applicable parties according to the Incident Reporting Policy.

[Save/Print](#)

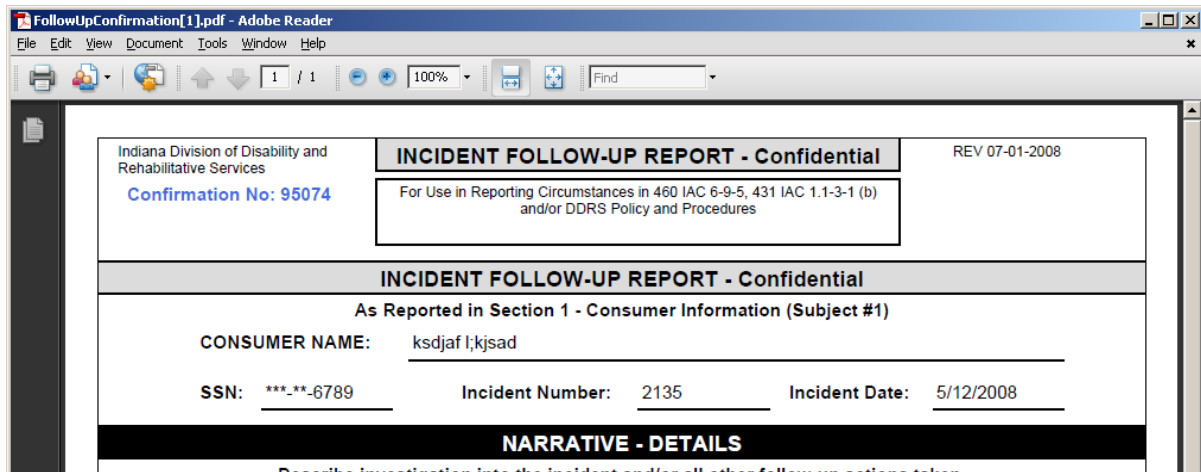
2.7.1 Saving or Printing the Incident Initial Report

After you submit an **Incident Initial Report**, you can save and print the report by selecting the **Save/Print** button. The **File Download** window appears, as shown in the following illustration:



Select **Open** to display the report or **Save** to save the report.

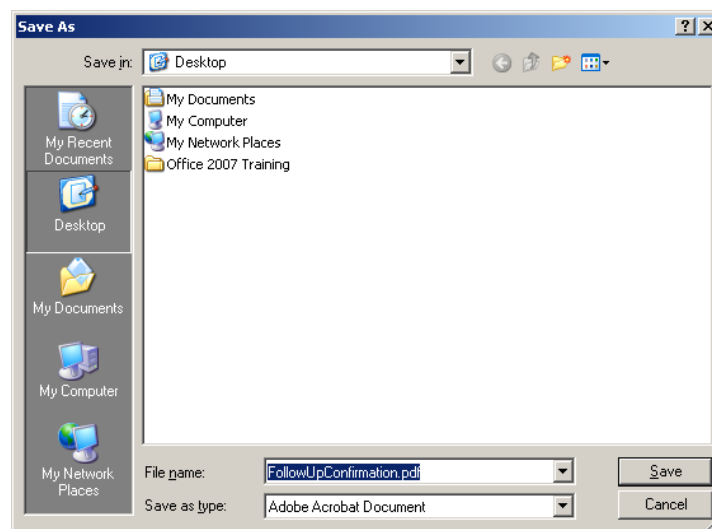
When you select **Open**, the system displays the report as a PDF file in a separate **Adobe Reader** window. The following partial illustration shows the top half of a test report in the **Adobe Reader** window:



You can:

- Use the **Print** icon on the standard toolbar to print the report.
- Use the **File > Print** menu on the menu bar to print the report.
- Use the **File > Save a Copy** menu on the menu bar to save a copy of the report.

When you select **Save** from the **File Download** window, the **Save As** window appears so that you can save the report as a PDF file in your desired folder. The following illustration shows an example of the **Save As** window:



Select the **Home** menu after you finish saving and printing the **Incident Initial Report**.

3. Completing an Incident Follow-Up Report

After you submit an **Incident Initial Report**, the system sends the report to the DART Web product, where a Quality Control Reviewer checks the report for completeness and accuracy. After the reviewer processes the report, the system sends an email to the email address in the **Reporting Person and Agency** section of the **Incident Initial Report**. The email message includes an incident number for the report, as shown in the following illustration:

```
This is an automatically generated e-mail. Please DO NOT REPLY to this e-mail address.

An INCIDENT FOLLOW-UP REPORT was received Friday, June 6, 2008 by DIVISION of AGING (DA) for the individual identified below. This report has been entered into our records.

This is to notify you that this incident is CLOSED and that an additional FOLLOW-UP report is NOT required to be submitted to the State at this time. DA can re-open the incident later, however, if additional information is received.

Follow-up reports should be submitted via the web at https://secure.in.gov/serv/fssa_ifur (there is an underscore '_' between 'fssa' and 'ifur' in this website address). Facsimile and emailed reports will only be accepted in emergency situations and with prior approval from DA.

Questions relating to incident reporting under DA programs should be emailed to DAQA@fssa.in.gov.

Thank you for your prompt attention to this notice. Our goal is to ensure that all incident reports filed are efficiently processed and appropriately resolved. We appreciate your continued commitment to the health and welfare of the consumers we serve.
-----
CONSUMER INFORMATION
Name: JOHN DOE

INCIDENT INITIAL INFORMATION
Incident#: 123456
Date of Incident: 06/05/2008
Reporting Entity: FICTICIOUS COMPANY, LLC
Reporting Person: BDDS/DA Worker
-----

Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient(s), please contact the sender by reply e-mail and destroy all copies of the original message.
```

Print the email message or record the incident number to use on the **Incident Follow-Up Report**.

Select **Incident Follow-Up** from the menu structure on the home page. The **Incident Follow-Up Report** appears, as shown in the following illustration:

Consumer Information	
First Name: <input type="text"/>	Last Name: <input type="text"/>
SSN: <input type="text"/>	Agency: [Select] ▼
Incident Number: <input type="text"/>	Incident Date: <input type="text"/>
Narrative Details	
Describe investigation into the incident and/or all other follow-up actions taken:	
<input type="text"/>	
Describe systemic actions being taken to assure health and safety issues:	
<input type="text"/>	
If abuse, neglect or exploitation was reported, was the abuse, neglect or exploitation substantiated by the entity responsible for follow -up? [Select] ▼	
Name of Person Submitting Report: <input type="text"/>	Title of Person Submitting Report: <input type="text"/>
Agency Submitting Report: [Select]	
Date Report Submitted: 11/6/2008	
Telephone Number of Person Submitting Report: <input type="text"/>	Email Address of Person Submitting Report: <input type="text"/>
<input type="button" value="Cancel Report"/> <input type="button" value="Preview Report"/>	

Important

All fields on the **Incident Follow-Up Report** are [required](#).

To complete the **Agency Submitting Report** field, click the **Select** button. A search window appears. Enter the first 1 to 3 characters of the reporting agency name in the text box and select **Search**. The system uses the entry to populate the drop down list in the **Select Reporting Agency** field, as shown in the following illustration:

The screenshot shows a search interface for selecting a reporting agency. It consists of two main sections:

- 1) Enter the first 1 to 3 characters of the reporting agency name:** A text input field contains the characters "are", and a "Search" button is located to its right.
- 2) Select Reporting Agency:** A dropdown menu is open, displaying a list of agency names. The top of the dropdown shows "AREA 03 AGING AND IN-HOME SERVICES OF NORTHEAST INDIANA, INC." with a small downward arrow. Below this is a "[Select]" option. The list includes:
 - AREA 01 AGENCY ON AGING
 - AREA 02 REAL SERVICES INC
 - AREA 03 AGING AND IN-HOME SERVICES OF NORTHEAST INDIANA, INC. (highlighted in blue)
 - AREA 04 AGENCY ON AGING & COMMUNITY ACTION PROGRAMS, INC
 - AREA 05 AGENCY ON AGING & COMMUNITY SERVICES, INC.
 - AREA 06 LIFESTREAM SERVICES, INC.
 - AREA 07 AGENCY ON AGING AND DISABLED
 - AREA 08 CICOA THE ACCESS NETWORK
 - AREA 09 IN-HOME & COMMUNITY SERVICES AGENCY
 - AREA 1: NORTHWEST INDIANA COMMUNITY ACTION CORPORATIONA mouse cursor is pointing at the highlighted "AREA 03" option. To the right of the dropdown list is a "Submit" button.

Select a reporting agency name from the list and then select the **Submit** button.

If you are searching for a name with a space or a period, you must include the space or period. For example, to search for St. James, enter **st.** and include the period.

3.1 Incident Follow-Up Report Preview

After you complete the fields in the **Incident Follow-Up Report**, select the **Preview Report** button. The system displays the **Incident Follow-Up Report** on your screen, which provides an opportunity to review the contents of the report before you submit it. The following illustration shows an example of an **Incident Follow-Up Report**:

Cancel Report		Edit Incident Follow-Up		Submit Incident Follow-Up Report	
		1 of 1		100%	
Indiana Division Of Aging		INCIDENT FOLLOW-UP REPORT - Confidential		REV 05-30-2008	
		For Use in Reporting Circumstances in 460 IAC 1.2-8-2 and/or DA Policy and Procedure			
INCIDENT FOLLOW-UP REPORT - Confidential					
As Reported in Section 1 - Consumer Information (Subject #1)					
CONSUMER NAME:		Joyce Smith			
SSN:	***-**-5128	Incident Number:	202007	Incident Date:	6/5/2008
NARRATIVE - DETAILS					
Describe investigation into the incident and/or all other follow-up actions taken.					
Consumer was stabbed in the arm with a fork during dinner.					
Describe systemic actions being taken to assume health and safety issues.					
Taking measures to separate victim and perpetrator during meals.					
If abuse, neglect and/or exploitation was reported, was the abuse, negelect and/or exploitation substantiated by the entity responsible for follow-up? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A					
Name of Person Submitting Report:			Title of Person Submitting Report (if designee, indicate so):		
K. Farra			Tech Writer		
Agency Submitting Report:			Date Report Submitted:		
ABC PROVIDER, INC			7/3/2008		
Telephone Number of Person Submitting Report:			Email Address of Person Submitting Report:		
(317) 234-5557			kent.farra@fssa.in.gov		

3.2 Submitting, Saving, and Printing an Incident Follow-Up Report

When you are satisfied that the **Incident Follow-Up Report** is accurate, select the **Submit Incident Follow-Up Report** button above the report to submit it. You can also use the buttons above the report to cancel the **Incident Follow-Up Report** or edit the information in the report.

When you select the **Submit Incident Follow-Up Report** button, the system displays:

- A message indicating that the report(s) were submitted to the DDRS/DA Central Office
- The confirmation number(s) for the report(s)
- A reminder to print or save a hard copy of the report(s)
- A **Save/Print** button

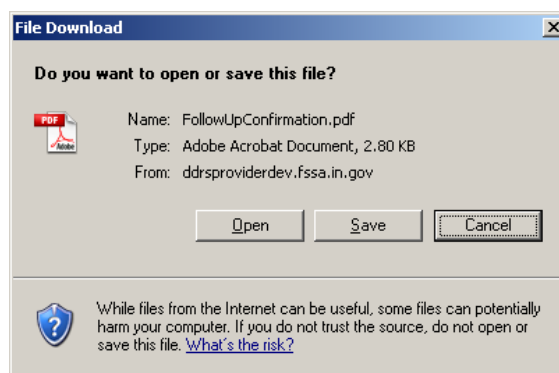
The following partial illustration shows the messages that appear when you submit an **Incident Follow-Up Report**:



The screenshot shows a confirmation page for the State of Indiana, Division of Disability and Rehabilitative Services. The page features the state seal on the left and the FSA (Indiana Family & Social Services Administration) logo on the right. The main heading is "INCIDENT FOLLOW-UP REPORT". Below this, a blue message states: "Incident Follow-Up Report has been SUCCESSFULLY submitted to the DDRS/DA Central Office. Confirmation Number(s): 95069." There are two links on the left: "Home" and "User Guide". A bold reminder reads: "Remember to either save or print this report so that you can provide copies to other applicable parties according to the Incident Reporting Policy." At the bottom, there is a "Save/Print" link.

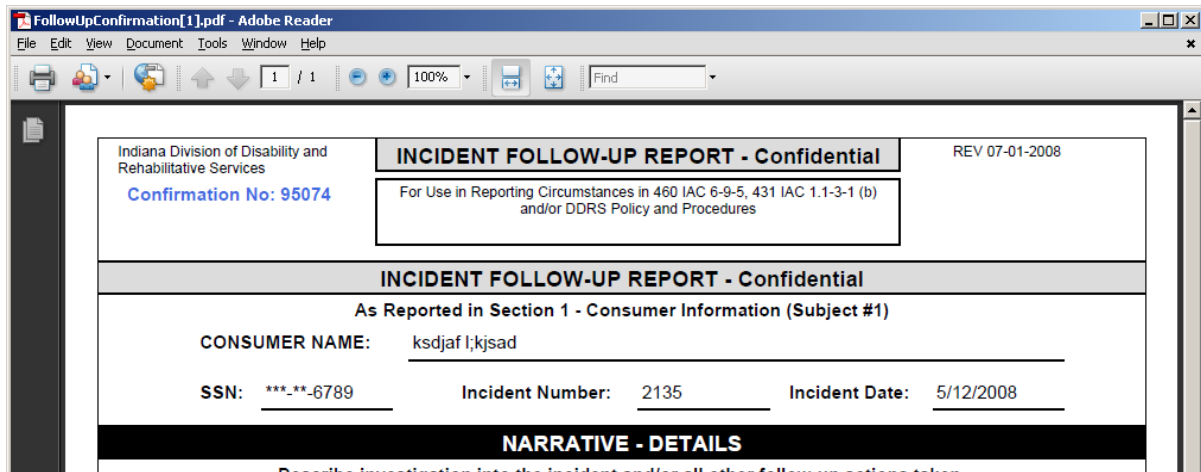
3.2.1 Saving or Printing the Incident Follow-Up Report

After you submit an **Incident Follow-Up Report**, you can save and print the report by selecting the **Save/Print** button. The **File Download** window appears, as shown in the following illustration:



Select **Open** to display the report or **Save** to save the report.

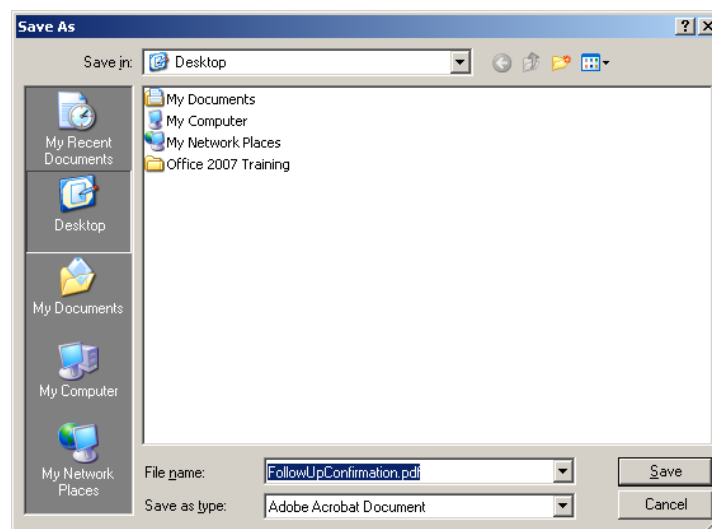
When you select **Open**, the system displays the report as a PDF file in a separate **Adobe Reader** window. The following partial illustration shows the top half of a test report in the **Adobe Reader** window:



You can:

- Use the **Print** icon on the standard toolbar to print the report.
- Use the **File > Print** menu on the menu bar to print the report.
- Use the **File > Save a Copy** menu on the menu bar to save a copy of the report.

When you select **Save** from the **File Download** window, the **Save As** window appears so that you can save the report as a PDF file in your desired folder. The following illustration shows an example of the **Save As** window:



Select the **Home** menu after you finish saving and printing the **Incident Initial Report**.

4. Printing a Blank PDF Form to Complete a Report by Hand

In addition to completing the electronic versions of the [Incident Initial Report](#) and [Incident Follow-Up Report](#), you can print a PDF of these reports to complete by hand.

Important

You must have the Adobe Reader program installed on your computer to view a PDF file. To install the Adobe Reader on your computer, enter the following URL into the **Address** field in your Internet browser:

<http://www.adobe.com/products/acrobat/readstep2.html>

The Adobe Reader web page appears.

Uncheck the **Adobe Media Player** check box and then select the gold **Download now** button. The Adobe Reader web page will provide the remaining steps in the downloading process.

To display an initial or follow-up report for printing, select the **Incident Forms** menu from the menu structure on the home page. A separate SharePoint web page appears that contains several provider PDF files, including files for the following IFUR incident reports:

- BDDS Incident Initial Report
- BDDS Incident Follow-up Report
- DA Incident Initial Report
- DA Incident Follow-up Report

Select the report to print. The **File Download** window appears.

Select **Open** from the **File Download** window. The system automatically runs the Adobe Acrobat program and displays the report.

The following illustration shows an example of the first page of an **Initial Incident Report** in the PDF format:

Indiana Division of Disability and Rehabilitative Services	INCIDENT INITIAL REPORT - Confidential For Use in Reporting Circumstances in 460 IAC 6-9-5, 431 IAC 1.1-3-1 (b) and/or DDRS Policy and Procedures	REV. 02-19-2007 Page <u>1</u> of <u>4</u>															
SECTION I - CONSUMER INFORMATION (Subject # 1)																	
SSN: _____ NAME LAST: _____ FIRST: _____																	
ADDRESS _____ CITY _____ ST _____ ZIP _____																	
DOB _____ (mm/dd/yyyy) COUNTY _____ GENDER <input type="checkbox"/> M <input type="checkbox"/> F																	
PRIMARY FUNDING SOURCE: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> AFC</td> <td><input type="checkbox"/> DD WVR</td> <td><input type="checkbox"/> SDC/SOF</td> <td><input type="checkbox"/> SUPP SRV WVR</td> </tr> <tr> <td><input type="checkbox"/> AUTISM WVR</td> <td><input type="checkbox"/> LP-ICF/MR</td> <td><input type="checkbox"/> SGL</td> <td><input type="checkbox"/> TITLE XX</td> </tr> <tr> <td><input type="checkbox"/> CFC</td> <td><input type="checkbox"/> NURSING HOME</td> <td><input type="checkbox"/> SLI RESIDENTIAL</td> <td></td> </tr> </table>			<input type="checkbox"/> AFC	<input type="checkbox"/> DD WVR	<input type="checkbox"/> SDC/SOF	<input type="checkbox"/> SUPP SRV WVR	<input type="checkbox"/> AUTISM WVR	<input type="checkbox"/> LP-ICF/MR	<input type="checkbox"/> SGL	<input type="checkbox"/> TITLE XX	<input type="checkbox"/> CFC	<input type="checkbox"/> NURSING HOME	<input type="checkbox"/> SLI RESIDENTIAL				
<input type="checkbox"/> AFC	<input type="checkbox"/> DD WVR	<input type="checkbox"/> SDC/SOF	<input type="checkbox"/> SUPP SRV WVR														
<input type="checkbox"/> AUTISM WVR	<input type="checkbox"/> LP-ICF/MR	<input type="checkbox"/> SGL	<input type="checkbox"/> TITLE XX														
<input type="checkbox"/> CFC	<input type="checkbox"/> NURSING HOME	<input type="checkbox"/> SLI RESIDENTIAL															
INDICATE WHICH of the FOLLOWING AGENCIES and/or INDIVIDUALS HAVE BEEN INFORMED																	
RES. PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> N/A LEGAL GUARDIAN? <input type="checkbox"/> YES <input type="checkbox"/> N/A NAME _____ DATE _____																	
HAB/VOC PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> N/A BDDS SC? (REQUIRED) <input type="checkbox"/> YES NAME _____ DATE _____																	
OTHER PROVIDER? <input type="checkbox"/> YES <input type="checkbox"/> N/A CASE MANAGER? <input type="checkbox"/> YES <input type="checkbox"/> N/A NAME _____ DATE _____																	
QMRP? <input type="checkbox"/> YES <input type="checkbox"/> N/A NAME _____ DATE _____																	
APS/CPS? <input type="checkbox"/> YES <input type="checkbox"/> N/A NAME _____ DATE _____ COUNTY _____ PHONE _____ METHOD _____																	
CORONER? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME _____ DATE _____																	
POLICE? <input type="checkbox"/> YES <input type="checkbox"/> N/A DATE _____																	
SUPERVISORY PROVIDER INFORMATION																	
RESPONSIBLE SUPERVISORY PROVIDER: _____ INDIVIDUAL SUPERVISING AT TIME OF INCIDENT: _____																	
SECTION II <i>This Section is intentionally blank</i>																	
SECTION III - REPORTING PERSON and REPORTING AGENCY																	
NAME LAST: _____ FIRST: _____ POSITION: _____ PHONE #: _____ EXTENSION: _____																	
DATE REPORT SUBMITTED: _____ REPORTING AGENCY: _____ E-MAIL ADDRESS: _____																	
SECTION IV - INCIDENT INFORMATION																	
INCIDENT DATE: _____ TIME: _____																	
WHERE OCCURRED? <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> COMMUNITY HAB.</td> <td><input type="checkbox"/> COMMUNITY JOB</td> <td><input type="checkbox"/> FAC. HAB. (ADC, ADL)</td> <td><input type="checkbox"/> HOME, AL</td> <td><input type="checkbox"/> HOME, FAMILY</td> </tr> <tr> <td><input type="checkbox"/> HOME, OWN</td> <td><input type="checkbox"/> HOSPITAL</td> <td><input type="checkbox"/> LP-ICF/MR</td> <td><input type="checkbox"/> NF</td> <td><input type="checkbox"/> SCHOOL</td> </tr> <tr> <td><input type="checkbox"/> WORKSHOP</td> <td><input type="checkbox"/> OTHER (Explain) _____</td> <td><input type="checkbox"/> SDC/SOF</td> <td><input type="checkbox"/> SGL</td> <td></td> </tr> </table>			<input type="checkbox"/> COMMUNITY HAB.	<input type="checkbox"/> COMMUNITY JOB	<input type="checkbox"/> FAC. HAB. (ADC, ADL)	<input type="checkbox"/> HOME, AL	<input type="checkbox"/> HOME, FAMILY	<input type="checkbox"/> HOME, OWN	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> LP-ICF/MR	<input type="checkbox"/> NF	<input type="checkbox"/> SCHOOL	<input type="checkbox"/> WORKSHOP	<input type="checkbox"/> OTHER (Explain) _____	<input type="checkbox"/> SDC/SOF	<input type="checkbox"/> SGL	
<input type="checkbox"/> COMMUNITY HAB.	<input type="checkbox"/> COMMUNITY JOB	<input type="checkbox"/> FAC. HAB. (ADC, ADL)	<input type="checkbox"/> HOME, AL	<input type="checkbox"/> HOME, FAMILY													
<input type="checkbox"/> HOME, OWN	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> LP-ICF/MR	<input type="checkbox"/> NF	<input type="checkbox"/> SCHOOL													
<input type="checkbox"/> WORKSHOP	<input type="checkbox"/> OTHER (Explain) _____	<input type="checkbox"/> SDC/SOF	<input type="checkbox"/> SGL														