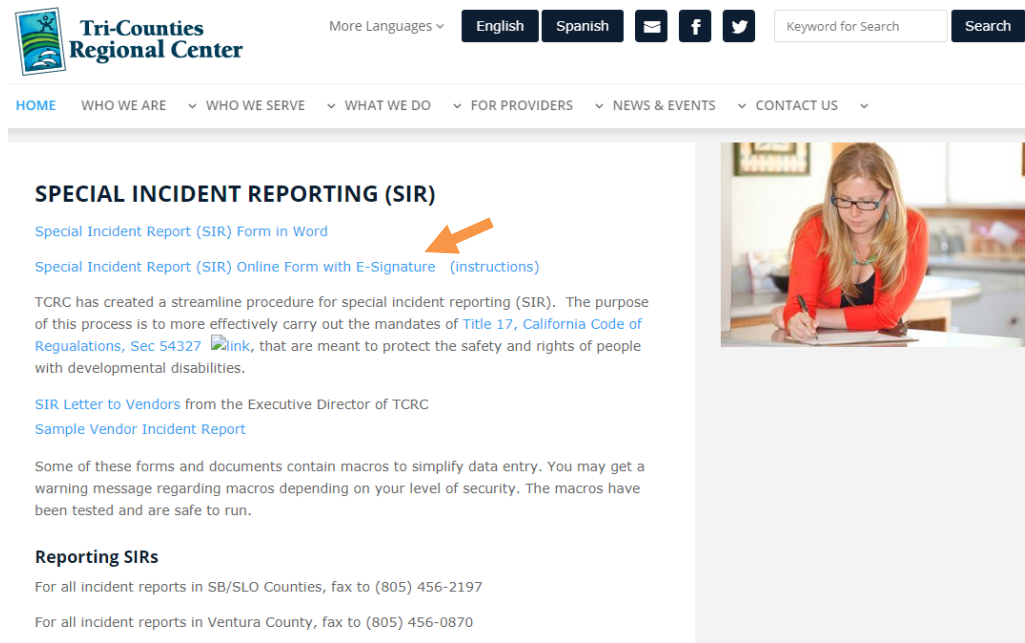


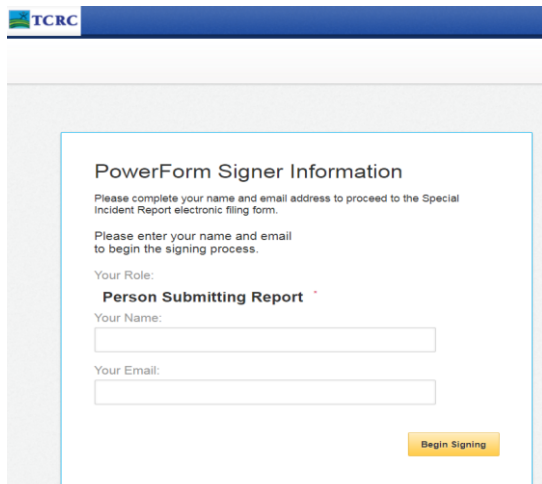
## TCRC Online SIR Submission Instructions:

- Access SIR reporting portal link at <http://www.tri-counties.org/for-providers/special-incident-reporting-sir/>



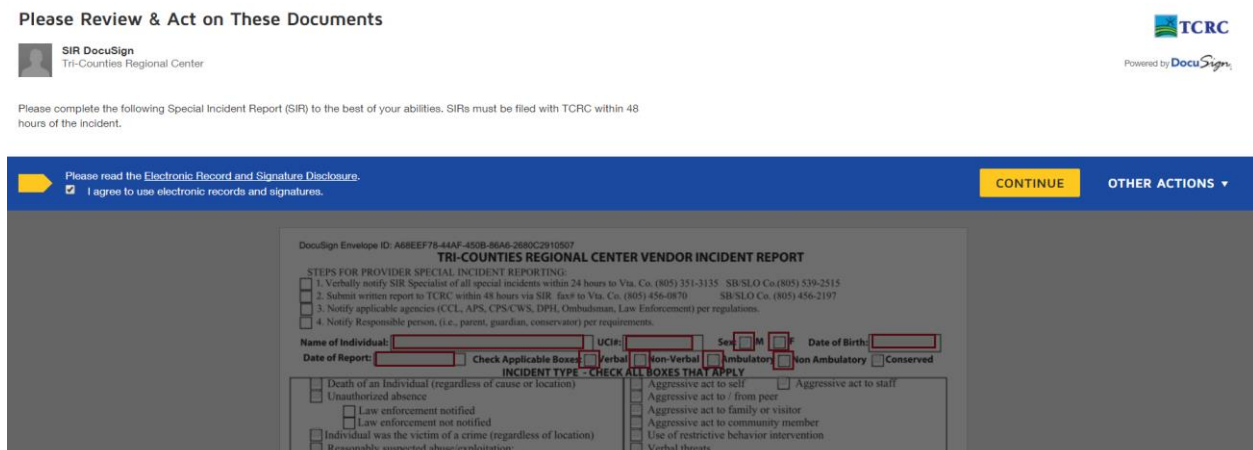
The screenshot shows the TCRC Regional Center website. At the top, there is a navigation bar with links for HOME, WHO WE ARE, WHO WE SERVE, WHAT WE DO, FOR PROVIDERS, NEWS & EVENTS, and CONTACT US. Below the navigation bar, there is a section titled "SPECIAL INCIDENT REPORTING (SIR)". This section contains links for "Special Incident Report (SIR) Form in Word" and "Special Incident Report (SIR) Online Form with E-Signature (Instructions)". An orange arrow points to the "Special Incident Report (SIR) Online Form with E-Signature (Instructions)" link. Below the links, there is a paragraph explaining the purpose of the SIR process and a link to "SIR Letter to Vendors from the Executive Director of TCRC". There is also a link to "Sample Vendor Incident Report". A section titled "Reporting SIRs" provides contact information for incident reports in SB/SLO Counties and Ventura County. On the right side of the page, there is a photograph of a woman in a red shirt sitting at a desk and writing on a document.

- Enter name and email, select “Begin Signing”



The screenshot shows the "PowerForm Signer Information" page. It contains a form with fields for "Your Name" and "Your Email". Below the form, there is a "Begin Signing" button. The page also includes instructions for completing the form and a section for "Your Role" with a dropdown menu set to "Person Submitting Report".

- Check box to agree to use and choose “Continue”



The screenshot shows the "SIR DocuSign" page. It features a "Please Review & Act on These Documents" section with a "SIR DocuSign" logo. Below this, there is a "Please read the Electronic Record and Signature Disclosure" section with a checkbox for "I agree to use electronic records and signatures." and a "CONTINUE" button. The main part of the page is a "TRI-COUNTIES REGIONAL CENTER VENDOR INCIDENT REPORT" form. It includes a "STEPS FOR PROVIDER SPECIAL INCIDENT REPORTING" section with four numbered steps. Below this, there is a "Name of Individual" field, a "UCIR" field, a "Sex" field (with options M and F), and a "Date of Birth" field. There is also a "Date of Report" field and a "Check Applicable Boxes" section with options for Verbal, Non-Verbal, Ambulatory, and Non-Ambulatory. The "INCIDENT TYPE - CHECK ALL BOXES THAT APPLY" section includes checkboxes for various incident types such as "Death of an individual", "Unauthorized absence", "Law enforcement notified", "Individual was the victim of a crime", "Reasonably suspected abuse/exploitation", "Aggressive act to self", "Aggressive act to/from peer", "Aggressive act to family or visitor", "Aggressive act to community member", "Use of restrictive behavior intervention", and "Verbal threats".

- Complete required boxes – begin by choosing “Start, and “Next” as section is complete, or by pressing “tab” key to move to next field

Please review the documents below. FINISH OT

DocuSign Envelope ID: 348D30EF-8F54-4B16-9855-D044AA4E733

**START**

**TRI-COUNTIES REGIONAL CENTER VENDOR INCIDENT REPORT**

STEPS FOR PROVIDER SPECIAL INCIDENT REPORTING:

1. Verbally notify SIR Specialist of all special incidents within 24 hours to Via. Co. (805) 351-3135 SB/SLO Co (805) 539-2515
2. Submit written report to TCRS within 48 hours via SIR fax# to Via. Co. (805) 456-0870 SB/SLO Co. (805) 456-2197
3. Notify applicable agencies (CCL, APS, CPS/CWS, DPH, Ombudsman, Law Enforcement) per regulations.
4. Notify Responsible person, (i.e., parent, guardian, conservator) per requirements.

Name of Individual:  UCI#:  Sex: ☐ M ☐ F Date of Birth:

Date of Report:  Check Applicable Boxes: ☐ Verbal ☐ Non-Verbal ☐ Ambulatory ☐ Non Ambulatory ☐ Conserved

**INCIDENT TYPE - CHECK ALL BOXES THAT APPLY**

<input type="checkbox"/> Death of an Individual (regardless of cause or location)	<input type="checkbox"/> Aggressive act to self	<input type="checkbox"/> Aggressive act to staff
<input type="checkbox"/> Unauthorized absence	<input type="checkbox"/> Aggressive act to / from peer	
<input type="checkbox"/> Law enforcement notified	<input type="checkbox"/> Aggressive act to family or visitor	
<input type="checkbox"/> Law enforcement not notified	<input type="checkbox"/> Aggressive act to community member	
<input type="checkbox"/> Individual was the victim of a crime (regardless of location)	<input type="checkbox"/> Use of restrictive behavior intervention	
<input type="checkbox"/> Reasonably suspected abuse/exploitation:	<input type="checkbox"/> Verbal threats	
<input type="checkbox"/> Physical <input type="checkbox"/> Psychological <input type="checkbox"/> Fiduciary	<input type="checkbox"/> Property damage	
<input type="checkbox"/> Sexual <input type="checkbox"/> Physical Restraint <input type="checkbox"/> Chemical Restraint	<input type="checkbox"/> Injury:	
<input type="checkbox"/> Other sexual incident:	<input type="checkbox"/> From a seizure <input type="checkbox"/> From a behavior episode <input type="checkbox"/> From a peer	
<input type="checkbox"/> Sexual Harassment <input type="checkbox"/> Inappropriate Contact	<input type="checkbox"/> Accident <input type="checkbox"/> Unknown Origin	
<input type="checkbox"/> Alleged violation of individual's rights	<input type="checkbox"/> Law enforcement contact	
<input type="checkbox"/> Reasonably suspected neglect:	<input type="checkbox"/> Arrest	
<input type="checkbox"/> Failure to provide medical care	<input type="checkbox"/> Incident which may result in criminal charges or legal action	
<input type="checkbox"/> Failure to prevent malnutrition or dehydration	<input type="checkbox"/> Other	
<input type="checkbox"/> Failure to provide care	<b>MEDICATION ERROR - REPORT ALL MEDICATION ERRORS</b>	
<input type="checkbox"/> Failure to prevent from health and safety hazard	<input type="checkbox"/> ANY MEDICATION ERROR	
<input type="checkbox"/> Failure to assist with personal hygiene or the provision of food, clothing or shelter	<input type="checkbox"/> Medication reaction requiring treatment beyond first aid	
<input type="checkbox"/> Emergency Room visit	<input type="checkbox"/> Medication refusal	
<input type="checkbox"/> Unplanned or unscheduled hospitalization due to:	<b>Medication(s) Involved</b>	<b>Date(s) and Time(s)</b>
<input type="checkbox"/> Cardiac-Related <input type="checkbox"/> Respiratory Illness		
<input type="checkbox"/> Diabetes-Related <input type="checkbox"/> Seizure-Related		
<input type="checkbox"/> Internal Infection <input type="checkbox"/> Wound/Skin Care		
<input type="checkbox"/> Nutritional Deficiencies <input type="checkbox"/> Other		
<input type="checkbox"/> Involuntary Psychiatric Admission		
<input type="checkbox"/> Voluntary psychiatric hospitalization		

box to mark FINISH

**NEXT**

☐ Failure to prevent malnutrition or dehydration

☐ Failure to provide care

☐ Failure to prevent from health and safety hazard

☐ Failure to assist with personal hygiene or the provision of food, clothing or shelter

☐ Emergency Room visit

☒ Unplanned or unscheduled hospitalization due to:

☒ Cardiac-Related ☐ Respiratory Illness

☐ Diabetes-Related ☐ Seizure-Related

☐ Internal Infection ☐ Wound/Skin Care

☐ Nutritional Deficiencies ☐ Other

☐ Involuntary Psychiatric Admission

☐ Voluntary psychiatric hospitalization

☐ Suicide episode: ☐ Threat ☐ Attempt

☐ Serious injury or accident, including:

☐ Dislocation ☐ Fracture

☐ Laceration requiring sutures/staples

☐ Burns, bites, puncture wounds or internal bleeding

☐ Poisoning

☐ Diagnosis of communicable disease/parasite

☐ Health and safety issue

☐ Other

**MEDICATION ERROR - REPORT ALL MEDICATION ERRORS**

☐ ANY MEDICATION ERROR

☐ Medication reaction requiring treatment beyond first aid

☐ Medication refusal

**Medication(s) Involved** **Date(s) and Time(s)**


**OTHER AGENCIES/INDIVIDUALS NOTIFIED:**

Agency/Individual	Contact Name	Contact Date	Telephone	Report Number
Tri-Counties Regional Center:				
Community Care Licensing:				
Licensing & Certification (DPH):				
Parent/Guardian/Conservator:				
Physician/Hospital:				
Child/Adult Protective Services:				
Long Term Care Ombudsman:				
Law Enforcement:				
County Coroner:				

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Date of Incident:  Time of Incident:  Location of Incident:

**DESCRIPTION OF INCIDENT (Title 17 requires a description of the alleged perpetrator, if applicable):**

test, description of incident; upload attachment (ie. typed word document) if additional space is needed

**NEXT**

(Attach a separate page for additional information)

**IMMEDIATE ACTION TAKEN BY SERVICE PROVIDER/VENDOR /OTHER:**

test, description of action taken; attach additional pages if more space is needed, or if providing supplemental documentation (ie. SOC 341)

(Attach a separate page for additional information)

**MEDICAL TREATMENT NECESSARY:** ☒ Yes ☐ No if yes, describe the nature of the treatment

test, description of medical treatment; attach additional pages if more space is needed, or if providing supplemental documentation (ie. discharge documentation)

Administered At:  Administered By:

**Optional Treatment, if any:**

-Attach additional pages if necessary; document must be available electronically

1 of 2

Location of Incident:

**DESCRIPTION OF INCIDENT (Title 17 requires a description of the alleged perpetrator, if applicable):**

test, description of incident; upload attachment (ie. typed word document) if additional space is needed

**IMMEDIATE ACTION TAKEN BY SERVICE PROVIDER/VENDOR /OTHER:**

test, description of action taken; attach additional pages if more space is needed, or if providing supplemental documentation (ie. SOC 341)

**Upload Attachment**

UPLOAD A FILE

DONE

(Attach a separate page for additional information)

**MEDICAL TREATMENT NECESSARY:**

Administered At:  Administered By:

**Optional Treatment, if any:**

**PLAN TO PREVENT FURTHER OCCURRENCES:**

test

(Attach a separate page for additional information)

-Choose "Upload" option only; fax option not available

**Attachments**

How would you like to add your attachments?

☐ Upload

☐ Fax

CONTINUE CANCEL

DocuSign Envelope ID: 349D30EF-8F54-4B16-9855-D044A44E733

Date of Incident:  Time of Incident:  Location of Incident:

**DESCRIPTION OF INCIDENT (Title 17 requires a description of the alleged perpetrator, if applicable):**

test, description of incident; upload attachment (ie. typed word document) if additional space is needed

**IMMEDIATE ACTION TAKEN BY SERVICE PROVIDER/VENDOR /OTHER:**

test, description of action taken; attach additional pages if more space is needed, or if providing supplemental documentation (ie. SOC 341)

(Attach a separate page for additional information)

**MEDICAL TREATMENT NECESSARY:** ☒ Yes ☐ No if yes, describe the nature of the treatment

test, description of medical treatment; attach additional pages if more space is needed, or if providing supplemental documentation (ie. discharge documentation)

Administered At:  Administered By:

**Optional Treatment, if any:**

**Attachments**

How would you like to add your attachments?

☒ Upload

☐ Fax

CONTINUE CANCEL

DocuSign Envelope ID: 349D30EF-8F54-4B16-9855-D044A44E733

Date of Incident:  Time of Incident:  Location of Incident:

**DESCRIPTION OF INCIDENT (Title 17 requires a description of the alleged perpetrator, if applicable):**

test, description of incident; upload attachment (ie. typed word document) if additional space is needed

**IMMEDIATE ACTION TAKEN BY SERVICE PROVIDER/VENDOR /OTHER:**

test, description of action taken; attach additional pages if more space is needed, or if providing supplemental documentation (ie. SOC 341)

(Attach a separate page for additional information)

**MEDICAL TREATMENT NECESSARY:** ☒ Yes ☐ No if yes, describe the nature of the treatment

test, description of medical treatment; attach additional pages if more space is needed, or if providing supplemental documentation (ie. discharge documentation)

Administered At:  Administered By:

**Optional Treatment, if any:**

- Click “Upload a File” and choose from your computer (ie. word document with additional description; hospital discharge documents, PDF, scanned images); Any attachments uploaded will be shown on screen after page 2 when complete
- Complete “Title,” “Vendor Name,” “Vendor number”, “Lic #” (if applicable), “Telephone Number”, “Date”

Administered by: [redacted] - Administered by: [redacted]

Follow-up Treatment, if any:

PLAN TO PREVENT FURTHER OCCURRENCES:

test: description of plan to prevent further occurrences; attach additional pages if more space is needed

(Attach a separate page for additional information)

COMMENTS (INCLUDE THE NAME/ADDRESS OF ANY WITNESSES TO THE INCIDENT)

Has this ever occurred before? ☐ Yes ☐ No If yes, please explain:

(Attach a separate page for additional information)

Report Submitted By:

Name (print): first name last name Title: [redacted]

Vendor Name: [redacted] Vendor Number: [redacted]

DPH / CCL Lic#: [redacted] Telephone Number: [redacted]

Signature: [redacted] Date: 10/5/2017

COMPLETE FRONT/BACK - CONFIDENTIAL CLIENT INFORMATION - W&I CODE, SECTION 4514 8/2011

Special Incident Report1.pdf 2 of 2

- Choose “Sign”

COMMENTS (INCLUDE THE NAME/ADDRESS OF ANY WITNESSES TO THE INCIDENT)

Has this ever occurred before? ☐ Yes ☐ No If yes, please explain:

(Attach a separate page for additional information)

Report Submitted By:

Name (print): first name last name Title: title

Vendor Name: TCRC Vendor Number: 12345

DPH / CCL Lic#: n/a Telephone Number: 805-539-2515

Signature: [redacted] Date: 10/5/2017

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- Review confirmation of electronic signature, confirm, then click “Adopt and Sign”

Adopt Your Signature

Confirm your name, initials, and signature.

\* Required

Full Name\* Initials\*

First name Last name FNLN

Select Style Draw

PREVIEW

Digitized by: first name last name DS FNLN

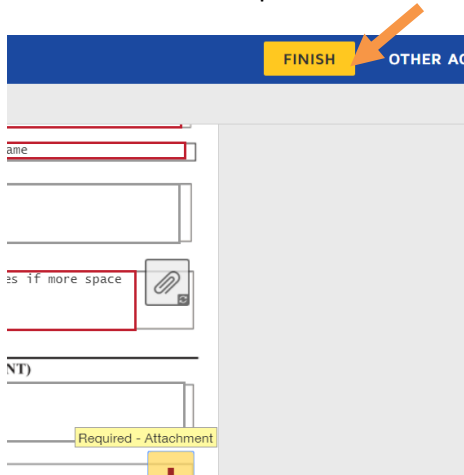
By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agency) use them on documents, including legally binding contracts - just the same as a pen-and-paper signature or initial.

ADOPT AND SIGN CANCEL

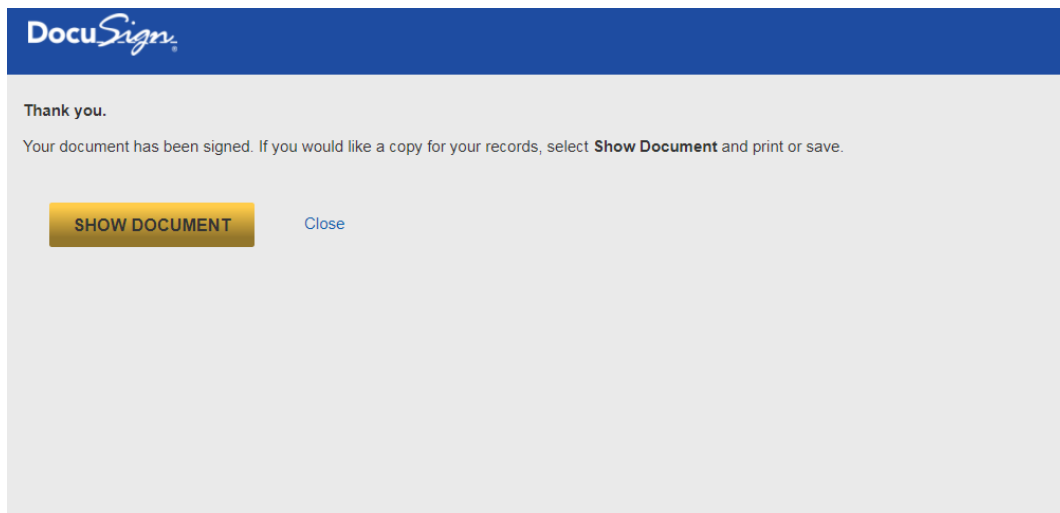
COMPLETE FRONT/BACK - CONFIDENTIAL CLIENT INFORMATION - W&I CODE, SECTION 4514 8/2011

Special Incident Report1.pdf 2 of 2

- Required fields will prompt for completion if left blank
- Choose “Finish” at top of document



- When complete, select “Show Document” to download/print/save copy for your records; THIS WILL BE YOUR ONLY OPPORTUNITY TO DO SO



## TCRC Online SIR Submission FAQs/Tips:

-How do I include supplemental documents, such as SOC341, hospital discharge paperwork? What if I need more space to describe incident or other sections?

-If additional space is needed for any section, or supplemental documents are to be provided, please utilize option to add/upload an attachment. Document must be readily available electronically from computer/device to upload

-The document will not allow me to select the box that I'd like to check. The document is prompting me for additional information, or will not allow me to enter text in a box.

-Certain categories are linked. For example, to choose a hospitalization type, the "Unplanned or Unscheduled Hospitalization due to..." incident type must be selected; to enter medications involved, the "Medication Error/Reaction/Refusal" type must be selected; to choose type of injury, "Serious Injury or Accident" type must be selected; if "Medical Treatment Necessary" is answered with "Yes," description will then be permitted *and* required

-How do I receive a copy of my report?

-After submission, portal will give option to save copy; THIS IS YOUR ONLY OPPORTUNITY to do so; a PDF will then open for you to save/print

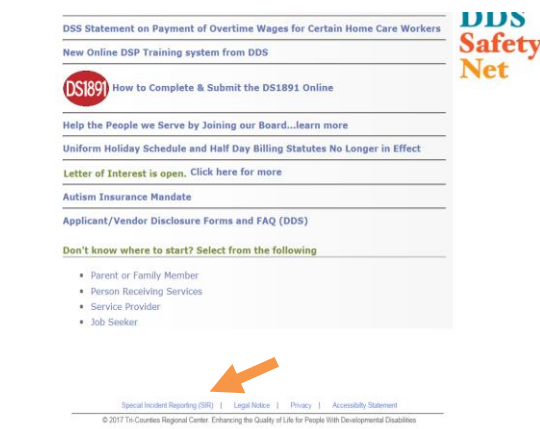
-Can I submit multiple reports/reports for multiple individuals?

-No, portal allows for submission of single report at a time.

-All reporting timelines still apply – verbal notification via phone line within 24 hours of incident; written report to be submitted to TCRC SIR Department via online portal or fax within 48 hours of incident; contact numbers are listed at top of report

-It is recommended to have all necessary information available when beginning reporting process. Online system does not allow for saving drafts, and will time-out after extended inactivity. Additional pages/supplemental documentation should be uploaded/readily available to attach electronically.

- SIR page is accessible from any other TCRC webpage ([www.tri-counties.org](http://www.tri-counties.org)) by scrolling to link at bottom of page



-UCI will require 7 digit UCI number

- Do not click the back button in your browser; this will take you back to sign-on screen and erase any data already entered

-Fax option is still available

-For questions or assistance, please contact Leslie Smith, TCRC SIR Coordinator, at 805-539-2515 or 805-351-3135