# VA New York / New Jersey Health Care Network
# HCHV Contract Program Incident Report

*(To be completed and submitted to the VISN Homeless Care Line Manager, COTR and Contracting Officer within 24 hours of an incident.)*

**Name of Veteran:**

**Social Security #:**

**Agency / Facility:**

**Contract #:**

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***Description of the Incident***

**Date of Incident:**

**Time of Incident:**

**Location of Incident:**

**Type of Incident:**

- ☐ Death (N)
- ☐ Fire (N)
- ☐ Drug / Police Raid (N)
- ☐ Suicide / Suicide Attempt
- ☐ 911 Call (Police / Fire Dept. / Paramedics / Other)
- ☐ Severe Medical Illness / Emergency
- ☐ Severe Psychiatric Illness / Emergency
- ☐ Sexual Assault
- ☐ Act of violence by veteran against other resident(s) or staff
- ☐ Abusive behavior by veteran against staff
- ☐ Act of violence by other resident(s) or staff against veteran
- ☐ Abusive behavior by staff against veteran
- ☐ Accident (Specify: _____)
- ☐ Medication Problem:
  - ◊ Medication not sent
  - ◊ Incorrect medication sent
  - ◊ Missing medications
  - ◊ Adverse drug reaction
- ☐ Other (Specify: _____)

*(N) = National report required)*

**(Please continue report on next page)**

***Brief Description of the Incident*** ***(please include circumstances leading up to the incident, names of witnesses, if any, and outcomes; dates, and attach additional pages as needed):***

***Action(s) taken by HCHV Contract Provider:***

***Action(s) taken by HCHV Coordinator:***

***Follow-Up Required (if any):***

**Name of VA Staff Contacted:**

**Report Completed By (Name and Title):**

**Date: _____**

**Signature: _____**

**Phone: _____**

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**Report filed:**
***A copy of this report should be sent to the VISN Contracting Officer, COTR and VISN Homeless Care Line Manager.***

**VA HCHV Coordinator: _____**

**Signature: _____ Date: _____**