



Unusual Incident Report

INSTRUCTIONS: Please reference [RFA Written Directives Section 11.06: Reporting Requirements](#). Notify Approval Agency (RFA worker) and Placement Agency (child/youth's assigned social worker or probation officer) within 24 hours or next business day by telephone, email, or fax. Follow up with this form within 7 calendar days of event if the required information is not provided in the initial notification. If sending this form by email, please use initials only to identify the child, youth, or nonminor dependent (NMD). Form may be faxed to 707-253-4672, Attn: RFA, or emailed to RFAinbox@countyofnapa.org. Keep a copy in the child/NMD's record.

Resource Family Name		RFA #	Phone Number
Address			
Date of Incident:		Time of Incident:	<input type="checkbox"/> AM <input type="checkbox"/> PM
Location of Incident:	<input type="checkbox"/> Resource Home	<input type="checkbox"/> School	<input type="checkbox"/> Park
	<input type="checkbox"/> CWS Agency		
Other:			
Name of Person Contacted & Date of Initial Notification			
RFA Unit	Social Worker/Probation Officer		Law Enforcement
Name:	Name:		Name:
Date:	Date:		Date:

Foster Child(ren) or NON-MINOR DEPENDENT(s) Involved or Impacted	Date of Birth	Sex
Name:		
Name:		
Name:		
Name:		
Other Persons Involved: (Indicate whether other persons involved are members of the Resource Home)		
Name:	Relationship:	

Type of Incident: Can involve Child, Nonminor Dependent, Resource Family, or other Residents		
Illness and Injury	Other Incidents	Removal from Resource Family
<input type="checkbox"/> Death	<input type="checkbox"/> Threat to physical safety	<input type="checkbox"/> Due to child/youth arrest
<input type="checkbox"/> Serious bodily injury <input type="checkbox"/> Suspected abuse or neglect: physical, sexual, emotional, or exploitation	<input type="checkbox"/> Threat to emotional safety <input type="checkbox"/> Significant change in physical or mental health	<input type="checkbox"/> Due to emergency medical or mental health treatment
<input type="checkbox"/> Injury or Illness requiring emergency medical treatment	<input type="checkbox"/> Fire or explosion	<input type="checkbox"/> Unplanned removal by placement agency
<input type="checkbox"/> Communicable disease outbreak	<input type="checkbox"/> Unusual absence of child	Other:
<input type="checkbox"/> Poisoning	<input type="checkbox"/> Absence of NMD > 72 hrs	



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Type of Injury: (Check all that apply):				
<input type="checkbox"/> None	<input type="checkbox"/> Bruise	<input type="checkbox"/> Swelling	<input type="checkbox"/> Possible Fracture/ Dislocation	<input type="checkbox"/> Other:
<input type="checkbox"/> Bite	<input type="checkbox"/> Burn	<input type="checkbox"/> Sprain	<input type="checkbox"/> Fracture/Break	

Additional Incident Information (if applicable)	
Child/Youth Threatened Other(s)	Name(s):
Child/Youth Injured Other(s)	Name(s):
Property Damage/Loss	Specify:
Child/Youth Committed Criminal Act	Specify:
Unintentional Drug/Substance Overdose	Specify drug/substance:
Intentional Drug/Substance Overdose	Specify drug/substance:
Suspicious/Unusual Cause of Death Other	Specify:

Description of Incident/Cause of Injury:

Action(s) Taken (Check all that Apply):	
<input type="checkbox"/> Child/Youth Taken to Hospital by Foster Parent/Caretaker	<input type="checkbox"/> Child/Youth Treated by Family Doctor Emergency Counseling Appointment
<input type="checkbox"/> Child/Youth Treated by Paramedics	<input type="checkbox"/> Child/Youth Treated in Emergency Room
<input type="checkbox"/> Child/Youth Treated by Foster Parent	Child/Youth Treated by Other:
<input type="checkbox"/> Child/Youth Admitted to Hospital Youth Admitted to Psychiatric Unit	<input type="checkbox"/> Youth Arrested Youth Placed in Juvenile Detention
<input type="checkbox"/> None	

Results of Actions Taken

Name of Individual Completing Report	Signature	Date

Form needs to be completed within 24 hours and sent to: RFAinbox@countyofnapa.org