



# Provider Investigation Report

For Home and Community Support Services Agency  
(or Home Health and Hospice) Provider use only.

## Fax Cover Sheet

Date: \_\_\_\_\_

To: **DADS Complaint Intake Unit, Attention: Intake Coordinator**

Fax Area Code and Telephone Number: **1-877-438-5827 (If 15 total pages or fewer)**

Office Area Code and Telephone Number: \_\_\_\_\_ - \_\_\_\_\_

Regarding DADS Intake ID Number: \_\_\_\_\_

Number of Pages, including cover: \_\_\_\_\_

From: (name of agency representative) \_\_\_\_\_

Title: (title of agency representative) \_\_\_\_\_

Fax Area Code and Telephone Number: \_\_\_\_\_ - \_\_\_\_\_

Office Area Code and Telephone Number: \_\_\_\_\_ - \_\_\_\_\_

### Provider Investigation Report Information

Agency Name		License Number
Street Address		
City, State, ZIP Code		County
Area Code and Telephone Number - -	Fax Area Code and Telephone Number - -	<input type="checkbox"/> Parent <input type="checkbox"/> Branch/Alternate Delivery Site

#### Confidential Document:

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For Home and Community Support Services Agency (or Home Health and Hospice) Provider use only.

Texas Department of Aging  
and Disability Services

### Provider Investigation Report

**For Home and Community Support Services Agency (or Home Health and Hospice) Provider use only.**

**Fax this report to:** 1-877-438-5827 (If 15 total pages or fewer)

**Mail this report to:** Texas Department of Aging and Disability Services, Consumer Rights and Services, Complaint Intake Unit E-249, P.O. Box 149030, Austin, TX 78714-9030

**(If more than 15 total pages):** Attach all documents and pertinent information that might be needed for DADS to complete the review of your investigation. Your DADS Regional Office may also contact you to request additional information to complete the review.

**Note to reporter:  
Do not mail if faxed.**

DADS Intake ID Number	Date Reported to DADS 800-458-9858	Time Reported :	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<b>DFPS Call ID Number</b>
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Provider Type HCSSA	License Number	Area Code and Telephone Number ( ) -
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Name	Fax Area Code and Telephone Number ( ) -
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Street Address	City	ZIP Code	County
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Incident Category <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation	Who made the allegation? <input type="checkbox"/> Client/Patient <input type="checkbox"/> Family <input type="checkbox"/> Other	When?
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Incident Date	Time :	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Location
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Description of the Allegation:

Client/Patient Name	<input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number	Date of Birth
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Client/Patient Street Address

City	State	ZIP Code	Area Code and Telephone Number ( ) -
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Payment Source

Functional Assistance Needs Status:  
 Total  Extensive  Minimal  No

If applicable, describe any special supervision required.

Services Provided (type, number of hours)

Independently ambulatory:  Yes  No — Interviewable:  Yes  No Capacity to make informed decisions:  Yes  No

Known history of:

Combativeness <input type="checkbox"/> Yes <input type="checkbox"/> No	Similar allegations <input type="checkbox"/> Yes <input type="checkbox"/> No	Wandering <input type="checkbox"/> Yes <input type="checkbox"/> No
Sexual misconduct <input type="checkbox"/> Yes <input type="checkbox"/> No	Verbal aggression <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical aggression <input type="checkbox"/> Yes <input type="checkbox"/> No

Diagnosis/Pertinent History:

**Alleged Perpetrator(s) (AP):** Attach copies of **any** criminal history check, nurse aide registry search and employee misconduct registry search conducted to verify the employability of the alleged perpetrator.

Staff Name (includes family if employed by agency)	Date of Birth	Social Security Number	License/Certificate Number

How was the AP identified?  By Name  By Description  Other: \_\_\_\_\_

AP:  Denied  Confirmed History of similar allegations? .....  Yes  No

DADS Intake ID Number	Agency Name	License Number
Did investigation reveal the presence of a witness? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Statement attached (signed and notarized if possible) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
Witness(es) Name	Client/Patient/Family/Staff/Other	Address
		Area Code and Telephone Number (       )       -
Injury or adverse effect? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		Assessment Date Time : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Description of Injury/Assessment:		
Treatment provided? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		Treatment/Transfer Date Time : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Treatment Location (name and complete address)		In-House? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
Agency Immediate Response		
Investigation Summary (attach additional sheets as necessary)		
Investigation Findings <input type="checkbox"/> Confirmed <input type="checkbox"/> Unconfirmed <input type="checkbox"/> Inconclusive <input type="checkbox"/> Unfounded		
Agency action <i>post-investigation</i>		

**Note:** DADS does not accept this report as complete until the reporter's signature, printed name, title and date have been entered below.

Signature	Title
Printed Name	Date