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 Cover Sheet

Date: _____

To: DADS Complaint Intake Unit, Attention: Intake Coordinator

Fax Area Code and Telephone No.: 1-877-438-5827 (If 15 total pages or fewer)

Office Area Code and Telephone No.: – –

Regarding DADS Intake ID No.: _____

No. of Pages, including cover: _____

From: _____

Name of Agency Representative: _____

Title of Agency Representative: _____

Fax Area Code and Telephone No.: – –

Office Area Code and Telephone No.: – –

Provider Investigation Report Information

Agency Name		License No.
Street Address		
City, State, ZIP Code		County
Area Code and Telephone No. – –	Fax Area Code and Telephone No. – –	☐ Parent ☐ Branch/Alternate Delivery Site

Confidential Document:

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Texas Department of Aging and Disability Services

Provider Investigation Report

Form 3613
October 2008

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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 No.	Date Reported to DADS 800-458-9858	Time Reported : ☐ A.M. ☐ P.M.	**DFPS Call ID No.**

Provider Type	License No.	Area Code and Telephone No.
HCSSA		– –

Name	Fax Area Code and Telephone No.
	– –

Street Address	City	ZIP Code	County

Incident Category	Who made the allegation?	When?
☐ Abuse ☐ Neglect ☐ Exploitation	☐ Client/Patient ☐ Family ☐ Other	

Incident Date	Time	Location
	: ☐ A.M. ☐ P.M.	

Description of the Allegation:

Client/Patient Name	☐ Female ☐ Male	Social Security No.	Date of Birth

Client/Patient Street Address

City	State	ZIP Code	Area Code and Telephone No.
			– –

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	☐ **Yes** ☐ **No**	Similar allegations	☐ **Yes** ☐ **No**	Wandering	☐ **Yes** ☐ **No**
Sexual misconduct	☐ **Yes** ☐ **No**	Verbal aggression	☐ **Yes** ☐ **No**	Physical aggression	☐ **Yes** ☐ **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 No.	License/Certificate No.

How was the AP identified? ☐ By Name ☐ By Description ☐ Other: _____

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

DADS Intake ID No.	Agency Name	License No.

Did investigation reveal the presence of a witness? ☐ **Yes** ☐ **No**
Statement attached (signed and notarized if possible) ☐ **Yes** ☐ **No**

Witness(es) Name	Client/Patient/Family/Staff/Other	Address	Area Code and Telephone No.
			– –

Injury or adverse effect? ☐ **Yes** ☐ **No**	Assessment Date	Time : ☐ A.M. ☐ P.M.

Description of Injury/Assessment:

Treatment provided? ☐ **Yes** ☐ **No**	Treatment/Transfer Date	Time : ☐ A.M. ☐ P.M

Treatment Location (name and complete address)	In-House?
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**

Agency Immediate Response

Investigation Summary (attach additional sheets as necessary)

Investigation Findings
☐ Confirmed ☐ Unconfirmed ☐ Inconclusive ☐ Unfounded

Agency action *post-investigation*

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**