INSTRUCTIONS FOR ANE REPORTS

1. Ensure the health & safety of the individual (Involve medical services or law enforcement, as needed)
2. Notify DHI/IMB immediately, by telephone, to the ANE Hotline at 1-800-445-6242
3. Complete the Immediate Action and Safety Plan (The hotline staff with assist you with this)
4. Contact your Alta Mira Service Coordinator or the On-Call Phone
   - Office: (505) 262-0801
   - On-call: (505) 991-2309
5. Complete the Abuse, Neglect and Exploitation or Report of Death Form (2015) when requested to do so by DHI/IMB
6. Submit form to DHI/IMB no later than 24 hours after the incident occurred
   - Fax: 1-800-584-6057
   - Email: incident.management@state.nm.us
   - On-line form: https://ane.health.state.nm.us/

NOTE: ALL SECTIONS ARE TO BE COMPLETED BY THE PERSON REPORTING THE INCIDENT

Immediate Action and Safety Plan

Top of page		Complete information concerning the alleged incident.
Section 1	Describe the Identified Safety Risk	Describe the safety risk of the victim/consumer. Include consumer(s) name in this section.
Section 2	Action to Address Risk	Describe what action has, or will be, taken to protect the consumer(s) from the identified safety risk.
Section 3	Plan Management	Describe who is responsible for implementing this plan and also who is responsible for communicating the plan.
Signature on back of page		Sign the form indicating that you are the person completing it.

ANE Report 2015

Section 1	Consumer Information	Complete as much demographic information as possible.
Section 2	Description of the Incident	• Complete the allegation type. Check as many boxes that pertain to your allegation. • Complete the questions regarding responsibility and provider agency. • Complete the incident date and time if known. • Describe the incident: Give information regarding before, during and after the incident.
Section 3	Additional Information	• Complete this section reporting the current diagnosis and any additional comments. • Signature of person completing sections 1-3
Section 4	Agency/Facility Information	Complete this section reporting the entire agency name, the name and phone number of your Service Coordinator as the Incident Coordinator. Ex: Alta Mira Specialized Family Services John Doe (505) 555-5555
Section 5	Administrative Information	Complete the appropriate Waiver service funding source.
Section 6	Notifications to Agencies	Document when you contacted the legal guardian and case manager and/or other entities.

NOTE: ALWAYS NOTIFY DHI/IMB TO REPORT SUSPECTED ABUSE, NEGLECT AND EXPLOITATION, DEATH, SUSPICIOUS INJURY AND ENVIRONMENTAL HAZARDS
Reports are required to be called in to 1-800-445-6242

Department of Health, IMB
Abuse/Neglect/Exploitation

Immediate Action and Safety Plan

Responsible Provider: _____

Alleged Victim(s) (include birthdate or social security number: _____

Accused Person(s): _____ Relationship to Alleged victim(s): _____

Did the incident create concern for the safety of consumer(s) served? ☐ Yes ☐ No

Immediate Action and Safety Plan drafted by: _____ Phone: _____
Name and Title

Section 1. - Required **Describe the identified Safety Risk(s)** When describing the safety risk, be sure to name the consumer(s).	**Section 2. - Required** **Action to address risk** What action has or will be taken to protect the consumer(s) from the identified safety risk(s)?	**Section 3. - Required** **Plan Management** How will the plan be managed? Who is responsible for implementing the plan? Who is responsible for communicating the plan?

Please see other side for required signature ➡

Signatures and Dates for Immediate Action and Safety Plan

To the best of my knowledge the attached Immediate Action and Safety has been implemented as described and all those who are responsible for carrying out the Immediate Action and Safety Plan have been alerted to the plan and have agreed to the implementation.

By typing your name, you are effectively signing this document.

Your typed name is acceptable as a replacement for your written signature.

Signature: _____ Date: _____

NEW MEXICO DEPARTMENT OF HEALTH

ABUSE, NEGLECT AND EXPLOITATION OR REPORT OF DEATH FORM (SFY 2015)

Always notify DHI/IMB immediately concerning incidents for individuals receiving the Developmental Disabilities Waiver (DDW), DD Mi Via Waiver, or Medically Fragile Waiver, Contact IMB On Call at 1-800-445-6242 and send A/N/E form within 24 hours via http://ane.health.state.nm.us or by fax at 1-800-584-6057.

SECTION 1 - CONSUMER INFORMATION

First Name:

Middle Name:

Last Name:

Social Security Number:

Gender: Male Female

Date of Birth (mm/dd/yyyy)

Street:

City

State:

Zip Code:

Telephone:

Assist with Ambulation:
- Gait Belt
- Walker
- Wheelchair

Personal Care:
- Bathing
- Incontinence
- Toileting
- Toothbrushing

Nutritional Fluid Intake:
- J-Tube
- G-Tube

Transfer:
- 2 or More Persons

Total Care:

None:

Other:

High Risk for Aspiration

Method of Communication:

SECTION 2 - DESCRIPTION OF INCIDENT

Report of Death: Death

Type of alleged incident:

Abuse: Physical Sexual Verbal Neglect Exploitation Suspicious Injury Environmental Hazards

Date of Incident: Time:

Location Where Incident Occurred:

Person Responsible for Individual's care at time of incident:

Is this person employed by a provider agency? If so, please state which agency:

What is the person's relationship if not a provider:

Were other individuals present? Yes No Please list other Consumers/Individuals Initials:

Other People?

Name: Title:

Name: Title:

Name: Title:

Name: Title:

To notify Child Protective Services of an incident involving a child, call: 1-800-797-3260
To notify Adult Protective Services of an elder or non-DD waiver adult call 1-866-654-3219

PLEASE DESCRIBE WHAT HAPPENED. BE SPECIFIC ABOUT WHO WAS THERE (by name) AND WHAT YOU SAW AND HEARD.

Before the incident

During the incident

After the incident

SECTION 3 - ADDITIONAL INFORMATION

Current Diagnosis:

Comments:

Person Completing Sections 1 & 2

Confidentiality Desired? Yes No

Name	Agency	Title / Relationship	Phone

Date and Time Completed:

SECTION 4 - AGENCY / FACILITY INFORMATION

Reporting Agency:

Incident Coordinator:

Phone:

SECTION 5 - ADMINISTRATIVE INFORMATION

*Check the applicable box(s) below:

- Developmental Disabilities Waiver
- Medically Fragile Waiver
- ICF/IID (JCM Only)
- Mi Via Waiver

Jackson Class Member (JCM) Yes No

DD PROGRAMS ONLY: TYPE OF RESIDENTIAL SERVICES RECEIVED BY THIS CONSUMER

Supported Living Family Living Respite Customized in Home Supports

Intensive Medical Living ICF/MR (Jackson Only) Mi Via DDW

Was an Immediate Action and Safety Plan Created? Yes No If Yes, please attach documentation (if not already provided)

SECTION 6 - NOTIFICATIONS TO AGENCIES REQUIRED

Legal Guardian: Notified None

Guardian Name:	Phone:	Date:	Time:	Person / Contact:

Street:	City	State:	Zip:	Title:

Independent Case Manager: Notified None

Case Manager Name & Agency:	Phone:	Date:	Time:	Person / Contact:

Street:	City	State:	Zip:	Title:

Other: Notified None

Name:	Phone:	Date:	Time:	Person / Contact:

Street:	City	State:	Zip:	Title:

PERSON COMPLETING SECTIONS 3, 4 & 5

Name	Agency	Title / Relationship	Phone

SECTION 7 - SIGNATURE

Name	Date

Abuse, Neglect and Exploitation Report
Required Signatures

		Date
Staff/Contractor Reporting Incident:	_____	_____
Person Writing Report:	_____	_____
Parent/Guardian Signature: (if applicable)	_____	_____
FSS Service Coordinator:	_____	_____
FSS Program Director:	_____	_____
Human Resources Director:	_____	_____
Executive Director:	_____	_____
QA/QI Committee Member:	_____	_____