Massachusetts Department of Public Health
Bureau of Substance Addiction Services / Office of Quality Assurance and Licensing

HEALTH AND SAFETY REQUIRED NOTIFICATIONS REPORTING FORM (105 CMR 164.035)

Please fax completed form (no cover sheet is necessary) to QAAL secure fax: 617-624-5395

Date of This Report: _____ Name/Title of Reporter: _____

Agency/Program Name: _____ Phone #: _____

Address: _____ BSAS Lic/Appr #: _____

The Bureau of Substance Addiction Services requires all licensed and/or funded programs to notify the Department immediately (24 hours) when serious events occur.

Please fill out the following form by checking the box that applies.

It is important to include any internal investigations/reports that the program has conducted, even if preliminary; please submit as soon as possible. If the internal investigation/report is still being conducted provide a timeline of when BSAS can expect the information.

☐ **Fire** or other event resulting in damage to the program or interruption of services.

☐ **Condition at the program posing a threat to client health or safety** (regardless of whether service is interrupted/suspended).

Specify condition posing threat to health/safety: ☐Loss of essential services, ☐ Limits on access to site, ☐ Unsanitary conditions (e.g., bed bugs), Other (specify type): _____

☐ **Serious injury** that occurred under program auspices, regardless of location. **(Ex. Overdose)**

☐ **Alleged abuse or neglect or physical or sexual assault**:

☐ Between/among clients and staff regardless of location ☐ Between or among clients at the program

Does the staff person hold a license or certification? ☐ Yes ☐ No

☐**Elopement** (only for adolescents).

☐**Involuntary closure** not due to an action by DPH/BSAS.

☐Confirmed case of **communicable disease**.

☐Report of **child abuse/neglect** alleged to have occurred at program. ☐ **51A Filed**

☐Report of **elder abuse/neglect** alleged to have occurred at program.

☐ Report of **abuse of a disabled person** alleged to have occurred at program.

☐**Civil action or criminal charge** against program or employee(s) relating to delivery of service.

☐**Other Event as per 164.035** (please specify): _____

If incident was reported to another agency, please identify: ☐DMH ☐DPH/DHCQ ☐ DCF ☐ Other (DYS, etc) ____

Date(s) of birth of child or youth involved if applicable:

ATTACH DESCRIPTION OF INCIDENT AND PROGRAM RESPONSE (may attach incident report filed with other agency), including where incident occurred or was alleged to have occurred, date/time of incident, date program learned of incident, and who filed the report.

Please do not scan or send client identifying information since email is not secure.