**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.**

**Revised: 1/18**