N.C. Department of Health & Human Services
Division of Health Service Regulation

Health Care Personnel Registry

24-HOUR INITIAL REPORT

Allegation Report by Facility/Provider

FAX: (919) 733-3207
Phone: (919) 855-3968
2719 Mail Service Center
Raleigh, NC 27699-2719

All allegations against health care personnel, including injuries of unknown source which appear to be related to resident abuse or neglect, must be reported to the HCPR within 24-hours. [see NC Gen. Stat. §131E-256(g)]	*Certain providers must report a reasonable suspicion of a crime with resulting serious bodily injury within 2-hours, and a reasonable suspicion of a crime without resulting serious bodily injury within 24-hours. [see 42 U.S.C. 1320b-25]*

Provider Information

County: ______ Facility/ Provider Type: ______

Facility/Provider Name: ______

Facility/Provider License #: ______ National Provider #: ______ Other ID #: ______

Main Office Phone #: ( ) ______ Main Office **(Secure)** Fax #: ( ) ______ Administrator/ Director Email Address: ______

Contact Person: ☐ Mr. ☐ Ms. ______ Title: ______

Administrator: ☐ Mr. ☐ Ms. ______ Title: ______

MAIN OFFICE Mailing Address: ______ City: ______ State: ______ Zip: ______

ACTUAL INCIDENT Location Address: ______ City: ______ State: ______ Zip: ______

Allegation/Incident Type

(check all that apply)

☐ REASONABLE SUSPICION OF A CRIME *(Explain under "Allegation/Incident Details" below)*

Is reasonable suspicion of a crime related to any allegation checked below? ☐ Yes ☐ No

☐ ① RESIDENT ABUSE	☐ ④ DIVERSION OF FACILITY DRUGS	☐ ⑦ MISAPPROPRIATION OF FACILITY PROPERTY
☐ ② RESIDENT NEGLECT	☐ ⑤ FRAUD AGAINST RESIDENT	☐ ⑧ MISAPPROPRIATION OF RESIDENT PROPERTY
☐ ③ DIVERSION OF RESIDENT DRUGS	☐ ⑥ FRAUD AGAINST FACILITY	☐ ⑨ INJURY OF UNKNOWN SOURCE

Allegation Description

Incident Date: ______ Time: ______ ☐ a.m. ☐ p.m.

Description of Physical or Mental Injury/Harm:

Resident Information

Resident Full Name: ☐ Mr. ☐ Ms. ______ Date of Birth: ______

Resident's Type of Care/ Service & Setting: ______

(Examples - Home Care, Nursing Home, Hospital/Acute Care, Day Program, CAP, CBS, Substance Abuse, Respite, etc.)

Accused Individual Information

Full Name: ☐ Mr. ☐ Ms. ______

Job Title: ______ Date of Hire: ______ Date of Birth: ______

Social Security # (required): ______ Taxpayer ID # or other ID #: ______

Last Known Address: ______ City: ______ State: ______ Zip: ______

Home Phone #: ( ) ______ Other Phone # (Cell phone, work, etc.): ( ) ______

Law Enforcement

Is there a Reasonable Suspicion of a Crime? ☐ Yes ☐ No Is there Serious Bodily Injury? ☐ Yes ☐ No

Incident reported to law enforcement? ☐ Yes ☐ No Date reported: ______ Time Reported: ______

Name of law enforcement agency: ______

Investigating Officer: ______ Phone #: ( )

➤ INVESTIGATION REPORT MUST FOLLOW WITHIN 5 WORKING DAYS ➤

The results of all investigations must be reported within five working days of the initial notification to the department. [see NC Gen. Stat. § 131E-256.(g)]

Failure to comply may result in a report to the agency having jurisdiction for compliance enforcement.

(Print Name and Title of Person Preparing Report)	*(Signature of Person Preparing Report)* *(Date Signed)*