MUI Reporting Form

Send to: MUIReports@SummitDD.org

summit DD
Developmental Disabilities Board

Information about the Individual:

Individual's Last Name: First Name:	DOB:	
Street Address:	Funding Source: LOCAL	
City:	State:	Zip:

Provider/Incident Information:

Provider at time of Incident:	Street Address: City: State: Zip:		
Residential Provider:	Street Address: City: State: Zip:		
Date of Incident:	Time:		
Date Provider Became Aware of the Incident:	Time:		
Location of Incident: (home in bathroom, at the mall, lunchroom at work):			
Description of Incident (please include in detail who, what, when, where, why, etc.):			
Immediate Actions to Ensure Health and Welfare of Individuals:			
Reported Category:	Injury:	Type:	Location:

Category A categories only: First Name of PPI: Last Name of PPI:	PPI's Relationship to Individual:
Full Name of Witness(es) (please include any peers if applicable):	Witness(es) Relationship to Individual:
Reporter Name:	Reporter Relationship:
Reporter Phone Number:	Reporter Email:

Notifications

Type	First Name	Last Name	Date/Time
Guardian Name:			
SSA Name:			
Residential Provider or ICF/DD:			
Other (including Advocate/ Other Service Provider):			
Law Enforcement (name, badge number, jurisdiction, and contact information)			
Children Services Worker Notified:			

Further Medical Follow up, if applicable, and any other Administrative Action:

Internal Use Only:

MUI or UI:	Decided Category:
MUI Number:	Assigned IA:
☐ Report Made after 3 PM	☐ Not Reported within 4 hours