

Substantiated Allegation of Abuse or Neglect Found Summary Report

For additional guidance in completing this form please see line by line instructions, available at www.opwdd.ny.gov.

State of New York
**OFFICE FOR PEOPLE WITH
DEVELOPMENTAL DISABILITIES**
MHL 16.34
SUMMARY REPORT

This form is to be used by provider agencies to provide a summary report in response to a request from OPWDD to search records for substantiated allegations relative to employees and volunteers when a substantiated allegation meeting the criteria for disclosure is found. The incident must have occurred before June 30th 2013.

The names and personally identifying information of individuals receiving services and other individuals (e.g. other staff) involved in the incident other than the prospective employee or volunteer should be excluded or redacted throughout.

This form must be typed.

Applicant Name:

Last Four of Social Security Number:

XXX - XX -

Person Receiving Services:

DDSQ:

Reporting Agency:

Date of Incident:

Time of Incident:

HH:MM

AM

PM

Incident must have occurred prior to June 30, 2013

Date of Discovery: (if appropriate) **Time of Discovery:**

HH:MM

AM

PM

Incident must have occurred prior to June 30, 2013

Incident Location:

Master Incident Number:

Agency Incident Number:

Incident Classification:

Introduction/Description of Incident:

Conclusion:

(Rev. 7/13/2017)

A large, empty rectangular box with a thin black border, occupying the majority of the page. This box is intended for the user to enter the summary report content.