MONTANA DEVELOPMENTAL DISABILITIES PROGRAM
FINAL INVESTIGATION REPORT FORM (FIRF)

AGENCY(S) INVOLVED:				
Name(s) & Title of Investigator:				
Date Investigator Assigned:		Time:		
Date Incident Occurred:		Time:		
Date Incident Reported:		Time:		
Alleged Victim(s):				
Alleged Perpetrator(s):				
Reporting Person and title(s):				
Witnesses Involved:				

	Agencies Notified	By Whom	Date/Time	Method
☐	Law Enforcement:			
☐	Parent/Legal Representative:			
☐	Case Manager:			
☐	QIS:			
☐	APS/CPS:			
☐	Licensing/QAD:			
☐	Provider:			
☐	Other:			

Method of Notification: 1-Phone 2-Fax 3-Email 4-Mail 5-Personal Contact

Describe Allegation at the Time of the Assignment:

1.)	Were there injuries to the victim?	☐ Yes	☐ No	☐ N/A
2.)	Are the injuries to the victim consistent with the allegation?	☐ Yes	☐ No	☐ N/A
3.)	Did the injuries result in hospitalization?	☐ Yes	☐ No	☐ N/A

Describe Immediate Actions Taken:

Date Investigator Visited the Site: _____ Time: _____ ☐ N/A

Evidence Protection, Preservation & Collection

Scene Secured: ☐ Yes ☐ No ☐ N/A

How Secured:

1.) Evidence Collected: ☐ Yes ☐ No ☐ N/A
2.) Evidence Logged: ☐ Yes ☐ No ☐ N/A
3.) Photographs Taken: ☐ Yes ☐ No ☐ N/A

Evidence collected (photos, physical, demonstrative, testimonial, etc):

ID #	Description	Date	Time

4.) Evidence Stored After Collection:
☐ Locked/Secure File
☐ Location of Evidence: _____
☐ Other: _____

Persons Interviewed (Chronological Order):

Date	Time	Name & Title

5.) Alleged Perpetrator Status:
☐ Removed From Contact
☐ Reassignment
☐ Administrative Leave
☐ NA

6.) Alleged Perpetrator Safeguards:
☐ Agreed to Speak with Investigator
☐ Union Representative, if applicable
☐ Consented to recording
☐ Other: _____

Summary

Evidence Summary/Scope of Investigation Questions answered (Includes: staff training, policies followed, protocols, plans of care, and person's safety):

1.)	Was there adequate staff present to ensure health and safety?	☐ Yes	☐ No ☐ N/A
2.)	Was the staff adequately trained in the components of the person's plan of care to ensure health and safety?	☐ Yes	☐ No ☐ N/A
3.)	Did the staff follow the provisions in the place of care?	☐ Yes	☐ No ☐ N/A

Investigator Recommendations/Provider Agency Follow-Up Actions:

Administrative Review Attached: ☐

Name of Investigator(s):	Date: