DEVELOPMENTAL DISABILITIES PROGRAM
ADMINISTRATIVE REVIEW
(To be completed at the conclusion of a Final Investigation or Triage Review)

Agency Name: ______________________________________________________________

Person’s Name: ______________________________________________________________

Date Investigative Report Received: ____________________ ☐ FIRF ☐ Triage

Description of the Incident as reported: __________________________________________

1) Were the provider agency and DDP policies followed in this incident? ☐ Yes ☐ No

2) Were notifications made within appropriate timeframes? ☐ Yes ☐ No

3) Were protections provided to victim(s)? ☐ Yes ☐ No

4) Was the investigation thorough and included enough information to answer the
   investigatory questions adequately? ☐ Yes ☐ No

5) Was the investigation completed within required timeframes? ☐ Yes ☐ No

6) Was the incident a result of a failure to follow federal regulation, Montana statute,
   the Administrative Rules of Montana, and/or the provider agencies’ policy? ☐ Yes ☐ No

7) Was there adequate staff present to ensure health and safety? ☐ Yes ☐ No

8) Was the staff adequately trained in the components of the person’s plan of care
   to ensure health and safety? ☐ Yes ☐ No

9) Did the staff follow the provisions in the place of care? ☐ Yes ☐ No

10) In the conduct of this investigation, were all applicable federal regulations,
   Montana Statutes, Administrative Rules of Montana, and/or provider agency
   policies followed? ☐ Yes ☐ No

Administrative Findings: ☐ Confirmed based on evidence
                         ☐ Not confirmed based on evidence
                         ☐ Inconclusive

Provider Agency Recommendations:

Provider Agency Requirements:

Provider Actions Taken Based on Investigation:

Agency Administrator/Chair of IMC (or RM for QIS) Investigation: __________________________

Date: ____________

Review Status:
☐ To be continued ☐ Closed