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