



Unusual Incident Report

INSTRUCTIONS: Please reference RFA Written Directives Section 11.06: Reporting Requirement. Notify Approval Agency (RFA worker) and Placement Agency (child/youth's assigned social worker or probation officer) within 24 hours or next business day by telephone, email, or fax. Follow up with this form within 7 calendar days of event if the required information is not provided in the initial notification. If sending this form by email, please use initials only to identify the child, youth, or nonminor dependent (NMD). Form may be faxed to 707-565-4399, Attn: RFA, or emailed to RFAFYC@schsd.org. Keep a copy in the child/NMD's record.

Resource Family Name		RFA #	Phone Number	
Address				
Date of Incident	Was SCAR submitted?	Date of Initial Notification & Person Contacted		
	<input type="checkbox"/> Yes Date:	RFA Unit	SW/PO	Law Enforcement
	<input type="checkbox"/> No			

Child(ren) or NMD(s) Involved or Impacted	Age	Sex	Date of Placement

Type of Incident: Can involve child, nonminor dependent, resource family, or other residents		
Illness and Injury	Other Incidents	Removal from Resource Family
<input type="checkbox"/> Death	<input type="checkbox"/> Threat to physical safety	<input type="checkbox"/> Due to child/youth arrest
<input type="checkbox"/> Serious bodily injury	<input type="checkbox"/> Threat to emotional safety	<input type="checkbox"/> Due to emergency medical or mental health treatment
<input type="checkbox"/> Injury or Illness requiring emergency medical treatment	<input type="checkbox"/> Fire or explosion	<input type="checkbox"/> Unplanned removal by placement agency
<input type="checkbox"/> Communicable disease outbreak	<input type="checkbox"/> Unusual absence of child	<input type="checkbox"/> Other:
<input type="checkbox"/> Poisoning	<input type="checkbox"/> Absence of NMD > 72 hrs	
<input type="checkbox"/> Suspected abuse or neglect: physical, sexual, emotional, or exploitation	<input type="checkbox"/> Significant change in physical or mental health	



Human Services Department

COUNTY OF SONOMA



Describe event or incident (include date, time, location, nature of incident, anything leading up to the incident, how individuals were affected, how those present responded to the incident, and steps taken since the incident to return to or ensure safety):

Did the incident require emergency medical treatment or hospitalization? ☐ Yes ☐ No
If yes, please name the attending physician and describe treatment, as well as any follow up treatment necessary.
Attach additional documentation if necessary

Additional Comments and Information

Name of Individual Completing Report	Signature	Date