



Comprehensive Rehabilitation Services Allegations or Incidents of Abuse, Neglect, or Exploitation of Persons with Disabilities Requirements

Upon notification of incidents, abuse, neglect, or exploitation allegations that involve a CRS participant, the provider is mandated to notify the Texas Health and Human Services Commission (HHSC) Complaint and Incident Intake, and, when applicable, law enforcement, immediately upon discovery and no later than twenty-four (24) hours of becoming aware of the incident. The provider must complete the CRS Incident Report Form and notify CRS by phone, email at CRS_Program@hhsc.state.tx.us, or eFax at 512-206-3981 of the suspected allegations/incidents immediately and no later than twenty-four (24) hours/one (1) calendar day upon discovery of the incident. Moreover, the provider is required to cooperate with CRS program staff in providing information and documentation pertaining to the incident. Additionally, the provider must follow all regulations outlined in [26 Tex. Admin. Code § 554.602](#) pertaining to Texas reporting requirements.

The following documents must be provided to the designated CRS program staff member as the documents become available:

- CRS Incident Report Form;
- The Facility Incident Report;
- Progress Notes pertaining to the incident;
- Medical Assessments;
- A copy of the participant's Individualized Program Plan (IPP);
- The provider's investigation report with supporting documentation;
- Documentation to illustrate that a report was made to the proper investigative agency, including the intake number, as applicable;
- A copy of the investigative agency's report upon completion, as applicable;
- A copy of a deficiency report with the investigation report, as applicable; and
- A copy of the resolution report for all incidences of abuse, neglect, and exploitation involving CRS participants upon completion. The report must include :
 - A summary of the issue;
 - Actions taken; and
 - The final outcome.



How to Report

Email: CRS_Program@hhsc.state.tx.us

eFax: 512-206-3981

Texas Department of Family and Protective Services (DFPS): 1-800-252-5400



Comprehensive Rehabilitation Services Incident Report Form

Section I: General Incident Information

Name of CRS participant involved in the incident: _____
CRS Case ID Number: _____ Participants DOB: _____
Date of incident: _____ Time: _____ am/pm
Location of incident: _____
Facility address: _____

Section II: Type of Incident (Check all that apply)

Abuse: <input type="checkbox"/>	Participant Substance Abuse: <input type="checkbox"/>	Hospitalization: <input type="checkbox"/>
Neglect: <input type="checkbox"/>	Staff Substance Abuse: <input type="checkbox"/>	Death: <input type="checkbox"/>
Exploitation: <input type="checkbox"/>	Use of Emergency Medical Services: <input type="checkbox"/>	Suicide: <input type="checkbox"/>
Sexual Abuse: <input type="checkbox"/>	Treatment at an Emergency Room: <input type="checkbox"/>	Fall: <input type="checkbox"/>
Verbal Abuse: <input type="checkbox"/>	Participant Misconduct: <input type="checkbox"/>	Fire/Smoke: <input type="checkbox"/>
Elopement: <input type="checkbox"/>	Staff Misconduct: <input type="checkbox"/>	Medication Error: <input type="checkbox"/>
Vehicular Accident: <input type="checkbox"/>	Misconduct Between Participants: <input type="checkbox"/>	Injury: <input type="checkbox"/>
Facility Equipment Failure: <input type="checkbox"/>	Participant Medical Device Failure: <input type="checkbox"/>	Pressure Injuries: <input type="checkbox"/>
Sudden Condition Change: <input type="checkbox"/>	Misappropriation of Participant Property: <input type="checkbox"/>	Suspicious Injuries: <input type="checkbox"/>
Choking/Aspirations: <input type="checkbox"/>	Unsafe Facility Conditions: <input type="checkbox"/>	Unexplained Injuries: <input type="checkbox"/>
Use of Restraints: <input type="checkbox"/>	Failure to Follow Care Plan: <input type="checkbox"/>	Adverse Drug Reaction: <input type="checkbox"/>
HIPAA Violation: <input type="checkbox"/>	Communicable Disease Outbreak: <input type="checkbox"/>	Missed/Delayed Treatment: <input type="checkbox"/>
Emergency Evacuation: <input type="checkbox"/>	Exposure to Hazardous Material: <input type="checkbox"/>	Other: <input type="checkbox"/> _____
	Incorrect Treatment: <input type="checkbox"/>	

Section III: Incident Reporter

Name: _____ Title: _____
Phone number: _____ Email: _____
Date: _____ Time: _____ am/pm
Was this incident reported to the facility supervisor? Yes ☐ No ☐
Supervisor name: _____ Title: _____
Was this incident reported to any other agency? Yes ☐ No ☐
Name of agency/s reported to: _____
Agency's incident report number: _____



Employee/s involved: _____

Employee/s title: _____

Employee/s phone number: _____

Section IV: Witness Account

Witness name: _____

Witness phone number: _____

Witness Observation: _____

Section V: Description of Incident

Provide a thorough description of the incident. Include the sequence of events, all individuals involved, their names, description of injuries, and the medication dosage/name, if applicable. Be sure the description addresses the who, what, where, when, why, and how of the incident. (Use additional paper if necessary)



Provide a thorough description of all actions taken or planned to be taken by the facility as a result of the incident.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's resting on a surface.

Printed Name: _____ Date: _____