Ohio | Department of Developmental Disabilities

ANNUAL REPORT – AGENCY PROVIDER

AGENCY PROVIDER NAME: _____

MUI ANNUAL REVIEW (January 1 through December 31) for the year _____

Agency providers are required to complete the Annual Review by January 31 and send to the County Board by February 28.

Total Number of MUI categories for the previous year: _____

Total Number of MUI categories for the same period 2 years ago: _____

Total Number of MUI categories for the same period 3 years ago: _____

Number of MUI categories by type:

MUI Categories	Previous year	2 years ago	3 years ago
Accidental/suspicious death			
Attempted suicide			
Death-Non-Accidental			
Exploitation			
Failure to Report			
Law Enforcement			
Medical Emergency			
Misappropriation			
Missing Individual			
Neglect			
Peer-to-Peer Act			
Physical Abuse			
Prohibited Sexual Relations			
Rights Code Violation			
Sexual Abuse			
Significant Injury			
Unapproved Behavioral Support			
Unanticipated Hospitalization			
Verbal Abuse			

Explain the reasons for any significant differences from year to year and any MUI categories with a high number of incidents (use additional pages as necessary):

_____

_____

_____

_____

_____

_____

_____

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Agency Trends and Patterns – current year

Identify and explain any agency-wide trends and any trends by residence, region, or program:

_____
_____
_____
_____
_____

Description of action plans and preventive measures to address these trends/patterns:

_____
_____
_____
_____

Agency Trends and Patterns - previous year

Previous year's agency–wide trends or trends by residence, region, or program:

_____
_____
_____
_____

Were the action plans and preventive measures effective?

_____
_____

Individual Trends and Patterns

Individuals with 5 or more MUI categories in 6 months or 10 or more MUI categories in 12 months in the current year:

Name: _____

MUI types: _____

Action plans and preventive measures taken to address this trend/pattern:

_____
_____
_____

Date the action plans and preventive measures were added to the individual's plan:_____
(Use additional pages to add additional individuals if needed.)

Date review wascompleted: _____

Name of person completing this review: _____