

## 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:

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

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## **Agency Trends and Patterns - previous year**

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

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Were the action plans and preventive measures effective?

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## **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:

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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 was completed: \_\_\_\_\_

Name of person completing this review: \_\_\_\_\_