

**Department of Developmental Services**  
*Abuse/Neglect Investigation Review*

Client Name Qualified Provider/Vendor	Report Date	Allegation Type	Qualified Provider/Vendor Findings	DDS DOI Review
				<input type="checkbox"/> Agree <input type="checkbox"/> Disagree

If applicable, please note the following:

- Specific nature and extent of assistance by the DDS DOI to the qualified provider/vendor in the completion of this investigation:

Explanation of modifications made to the components of the investigation submitted by the qualified provider/vendor:

- Page(s):
- Signature(s):
- Statement(s):
- Documentation to support findings:
- Findings/Summary:
- Other:

If applicable, specific rationale for disagreement with the findings of the qualified provider/vendor:

DDS Lead Investigator Signature and Date

I agree / do not agree [circle one] with the DDS Lead Investigator, and recommendations.

If applicable, specific rationale for disagreement:

DDS Regional Director/Designee Signature and Date