

# FSSA Incident Summary Report

for:

**The State of Indiana  
Family and Social Services Administration  
Privacy & Security Office  
402 W. Washington Street, RM. W353  
Indianapolis, IN 46204**

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*Click in box options, select and/or insert text in all sections 'except' for sections 2, 15 and 16, save, and send completed form with a copy of the actual document or form(s) containing the information disclosed as attachments securely to the FSSA Privacy & Security Office via E-mail at [fssa.privacyoffice@fssa.in.gov](mailto:fssa.privacyoffice@fssa.in.gov).*

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Section 1

**Incident Occurrence**

Date

**Date incident reported to the  
FSSA Privacy & Security Office?**

Date

**Was a full Social Security Number  
disclosed (all 9 digits)?**

Yes\*  No

*\*If yes, complete this form, forward & notify the FSSA Privacy & Security Office immediately.*

Section 2

**Incident Number**

*('Section 2' is completed by the FSSA Privacy & Security Office.)*

Section 3

*If involved, provide Contractor Employee/Business Associate Information (i.e. Xerox, etc..)*

Contractor Employee Company Name

City

Company Address

State  Zip Code

**Contractor Employee/Business Associate**

First Name

Last Name

Title (Eligibility Assoc., Clerk, etc.)

E-mail

Phone Number

Section 4

**State division/program involved?**

*Division involved?*

*Program involved?*

- Health Coverage       TANF  
 SNAP                       \*Other(s)

\*If 'Other(s)' is selected,  
describe here:

Section 5

**Name & Title of individual(s) submitting this report?**

*(Add contact information for individual(s) listed here into 'Section 14')*

Section 6

**Who first discovered the incident?**

*(i.e. agency or state workforce member - Add contact information for individual(s) listed into 'Section 14')*

*Name/Title*

Section 7

**Narrative of Incident\***

**Describe incident specifying dates, incident discovery, how and why it occurred, and what client personal information in the incident was improperly disclosed for each person involved.**

*Please  
enter your  
narrative  
here:*

**Incident Response Action** (Description of what has been done to correct, date/return of information disclosed, etc..)

**Individuals affected by the incident (victim)?**

How many individuals who had information disclosed improperly were involved?

Number

Provide name/  
address, case  
number along  
with pertinent  
information of  
and about the  
individuals  
affected:

**Who received the improperly disclosed client information?**

\*Name/address  
of individual(s)  
or organization  
(s) who  
received the  
improperly  
disclosed client  
information:

\*Relationship to the victim?

None

Family

Friend (Unrelated)

Agency or Community Organization

\*Other

\*If 'other', describe:

**Incident type?**

Please select as many as apply, as appropriate, to describe occurrence:

- Unauthorized Access/Disclosure
  - Verbal Disclosure
  - 'Co-mingled' Records
  - Mailed to the Wrong Recipient.
- Theft
- Loss
- Improper Disposal
- Unknown
- Hacking/IT Incident
- Other

\*If 'Other' is selected, describe here:

**Location of information improperly disclosed or at risk?**

Please select as many as apply as, appropriate, to describe occurrence:

- Laptop
- Desktop Computer/Application
- E-mail
- Other Portable Electronic Device (i.e. USB Device)
- Electronic Medical Record
- Network Server
- Paper
- Other\*

\*If Other is selected, describe here:

**Client personal information improperly disclosed in the incident?**

**Demographic Information**

- Name
- Social Security Number
  - Partial (4 digits only)
  - Full (9 digits)
- Address/Zip
- Driver's License
- Date of Birth
- State of Indiana case number/identifier.
- State of Indiana medicaid 'RID' number.
- \*Other

- Passport
- Citizenship/Immigration
- Birth Certificate

\*Enter type of:

**FSSA agency specific forms involved/disclosed?**

- Yes\*
- No

**\*Note: Please attach copies of documents entered and forward along with this form.**

\*Provide detailed listing of form type(s) involved (Ex. Pending verifications form, employment verification for earnings, SMRT packet, etc.).

**Financial Information**

- Bank
- Employment
- Credit Card
- Claim(s) Information
- \*Other

\*Enter type of:

**Clinical Information**

- Diagnosis/Conditions
- Lab Results
- Medications
- \*Other Medical Information

\*Enter type of:

**Provide contact information of all involved in the incident.**

Name	Title	Division/Program Area	Phone w/AC	E-mail

**Privacy Office Actions & Conclusion** (*Section 15' is completed by the FSSA Privacy & Security Office.*)

**OAG Initial Notice**    **Date**                       **Media Notice?**     Yes     No  
**Substitute?**                       Yes     No  
**Written notice issued?**     Yes     No                      **HHS Notice?**     Yes     No  
  
**Date individual notice was provided?**                       **Incident Closure**    **Date**   
  
**Action Taken:**     Mitigation     Sanctions     Policy & Procedures     Sec./Privacy Safeguards  
  
 \*Other    \* Brief Name Type:

**Conclusion:**

### Distribution List

*(Section 16' will be completed by the FSSA Privacy & Security Office.)*

*[i.e. Division Director; Deputy Director; Facility Superintendent; Others]*

*Note: The FSSA Privacy & Security Office will determine the appropriate distribution of the final report.*

Name	Title	Agency/Department