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| **INCIDENT AND EMERGENCY REPORT** |
| **IDENTIFYING DATA:**Person Served: Phone: Address: Date of incident:        Time of incident:        (indicate am or pm)Location of incident:  |
| **TYPE OF INCIDENT OR EMERGENCY (check all that apply):**

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| [ ]  Serious injury\* | [ ]  Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team | [ ]  Conduct by a person served against another person served (see 245D.02, subd. 11 for severity) |
| [ ]  Medical emergency |
| [ ]  Unexpected serious illness | [ ]  Maltreatment of a minor |
| [ ]  Significant unexpected changes  in an illness or medical condition  of a person that requires the  program to call “911,” physician  treatment, or hospitalization\*  | [ ]  Sexual activity between persons served involving force or coercion  |
| [ ]  Maltreatment of a vulnerable  adult |
| [ ]  Death of a person served\* |
| [ ]  An act or situation involving a person that requires the program to call “911,” law enforcement, or the fire department  | [ ]  Emergency use of manual restraint (complete the *EUMR Incident Report* form)  |
| [ ]  A person’s unauthorized or unexplained absence from a program | [ ]  Emergency (state specific  type):  |

\*Reporting of these incidents must also be made to MN Department of Human Services and MN Office of the Ombudsman.**Describe the incident and emergency including the effect on the person:** **Describe the response to the incident or emergency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and title of staff Date |

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| **REQUIRED NOTIFICATIONS** (completed within 24 hours of discovery or receipt of information that the incident occurred)**:**

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| Legal representative: | Date:  | Time:  | am/pm | [ ]  Left message |
| Case manager: | Date:  | Time:  | am/pm | [ ]  Left message |
| Designated emergency contact: | Date:  | Time:  | am/pm | [ ]  Left message |
| Other: [ ]  **N/A** | Date:  | Time:  | am/pm | [ ]  Left message |
| DHS Licensing Division: [ ]  **N/A** | Date:  | Time:  | am/pm | [ ]  Left message |
| MN Office of the Ombudsman: [ ]  **N/A** | Date:  | Time:  | am/pm | [ ]  Left message |
| MAARC/Child Protection Agency [ ]  **N/A**Name of intake worker:  | Date:  | Time:  | am/pm |

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**Send to:**

**Lifeworks Services, Inc.**

**Attention: PS/R Fiscal Supervisor**

**2965 Lone Oak Drive, #160**

**Eagan, MN 55121**

**Or fax to Lifeworks Services, Inc.**

**Attn: PS/R Fiscal Supervisor**

**Fax: 651-454-3174**

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| **DESIGNATED COORDINATOR REVIEW AND RECOMMENDATION:**

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| 1. Was the person’s *Coordinated Service and Support Plan Addendum* implemented as applicable?

[ ]  Yes [ ]  No: if no address in the corrective action section of this reviewWere policies and procedures implemented as applicable?[ ]  Yes [ ]  No: if no address in the corrective action section of this review |

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| 1. Identification of patterns:
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| 1. Is corrective action necessary based upon the review? [ ]  Yes [ ]  No: if yes, what corrective action will be implemented as necessary to reduce occurrences:
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| **DATE SENT TO COMPLIANCE COMMITTEE:**  |