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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):**   |  |  |  | | --- | --- | --- | | 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 changesin an illness or medical conditionof a person that requires theprogram to call “911,” physiciantreatment, or hospitalization\* | Sexual activity between persons served involving force or coercion | | Maltreatment of a vulnerableadult | | 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 orunexplained absence from a program | Emergency (state specifictype): |   \*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)**:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | 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 | |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of staff person who notified the persons or entities Date |

**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:**   |  | | --- | | 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 review  Were policies and procedures implemented as applicable?  Yes  No: if no address in the corrective action section of this review |  |  | | --- | | 1. Identification of patterns: |  |  | | --- | | 1. Is corrective action necessary based upon the review?  Yes  No: if yes, what corrective action will be implemented as necessary to reduce occurrences: |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Designated Coordinator Date |
| **DATE SENT TO COMPLIANCE COMMITTEE:** |