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| **INCIDENT AND EMERGENCY REPORT** |
| **Identifying data**  Program or person served:  Phone: Address: |
| **Type of incident or emergency (check all that apply)**   |  |  |  | | --- | --- | --- | | Serious injury\* | Any mental health crisis that requires the program to call “911,” a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate | Conduct by a person served against another person served (see 245D.02, subd. 11 for severity) | | Medical emergency, unexpected serious illness, or significant unexpected changes in an illness or medical condition of a person that requires the program to call “911;” physician, advanced practice registered nurse, or physician assistant treatment; or hospitalization | | Maltreatment of a minor | | 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 orunexplained 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.  Date of incident:        Time of incident:        (indicate am or pm)  Location of incident:  **Describe the incident and emergency including the effect on the person (delete unused rows)**   |  | | --- | |  | |  | |  | |  | |  | |  | |  | |  |   **Describe the response to the incident or emergency (delete unused rows)**   |  | | --- | |  | |  | |  | |  | |  | |  | |  | |  |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name and title of staff who responded 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 | | Rule 203 licensor (family foster care only): **N/A** | 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 | | MN Office of Health Facility Complaints (ICF/DD only):  **N/A** | Date: | Time: | am/pm | Left message | | The MAARC/CEP/Child Protection Agency  **N/A**  Name of intake worker: | Date: | Time: | am/pm | | | Was an internal maltreatment report filed?  Yes  No, if no, why: | | | | |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of staff person who notified the persons or entities Date |
| **Designated Manager review and recommendation**   |  | | --- | | 1. Was the person’s *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 and/or Designated Manager Date |