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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)**

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| [ ]  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 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.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)**

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**Describe the response to the incident or emergency (delete unused rows)**

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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 |
| 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:  |

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| **Designated Manager review and recommendation**

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| 1. Was the person’s *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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