LifeWORKS
A nonprofit serving people with disabilities

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* ☐ Medical emergency	☐ 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)
☐ Unexpected serious illness ☐ Significant unexpected changes in an illness or medical condition of a person that requires the program to call "911," physician treatment, or hospitalization*	☐ Maltreatment of a minor ☐ Maltreatment of a vulnerable adult	☐ Sexual activity between persons served involving force or coercion ☐ 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

This information can be made available
In an alternate format upon request.
Our TTY phone number is 651-365-3736.
Equal Opportunity Employer.

Lifeworks
A nonprofit serving people with disabilities

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

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

2. Identification of patterns:

3. 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: