**Emergency Report and Internal Review**

REQUIREMENTS FOR USE OF THIS SAMPLE DOCUMENT: 245D license holders are responsible for modifying this sample for use in their program. At a minimum, you must fill in the blanks on this form. You may modify the format and content to meet standards used by your program. This sample meets compliance with current licensing requirements as of August 1, 2022. Providers remain responsible for reading, understanding and ensuring that this document conforms to current licensing requirements. DELETE THIS HIGHLIGHTED SECTION TO BEGIN MODIFYING THIS FORM.

Program Name:

Date of emergency: \_\_ Time of emergency: \_\_\_\_\_\_ 🞏 am / 🞏 pm

Location of emergency:

"Emergency" means any event that affects the ordinary daily operation of the program including, but not limited to, fires, severe weather, natural disasters, power failures, or other events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving to an emergency shelter, or temporary closure or relocation of the program to another facility or service site for more than 24 hours.

This report must be completed within 24 hours of the emergency or within 24 hours of when the program became aware of the emergency.

**This form is completed when an Event AND a Response are checked below.**

1. **Emergency Type** (check all that apply):

Event:

□ Fire

* Severe weather
* Natural disaster
* Power failure
* Other event that threated the immediate health and safety of a person

Response:

□ Calling 911

* Emergency evacuation
* Moving to an emergency shelter
* Temporary closure or relocation of the program for more than 24 hours
1. **Description of emergency:**

NOTE: People receiving services do not need to be identified who were affected by or involved in the emergency. If the emergency resulted in an incident to a person, then an Incident Report and Internal Review form must be completed for that person.

1. **Description of staff response to the emergency:**

🞏 Applicable support plan addendum(s) were implemented for person(s) involved.

🞏 Applicable program policies and procedures were implemented as written.

Staff person(s) who responded to the emergency:

Name and signature of reporting staff Date

1. **Internal Review**
2. Was the emergency similar to past events with the persons, staff, or the services involved?

□ Yes □ No If yes, identify the patterns, if any.

1. Based on the internal review, is there a need for corrective action by the program to protect the health and safety of the persons receiving services and to reduce future occurrences?

□ Yes □ No If yes, identify the corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the program. [Attach relevant documentation. Insert name of staff person assigned to take corrective action and the specified time period in which corrective action will occur.]

Name and signature of staff completing internal review Date