

Program Name _____

Date of Emergency _____ Time of Emergency _____

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.

Emergency Type (check all that apply)	
Event	<input type="checkbox"/> Fire <input type="checkbox"/> Power failure <input type="checkbox"/> Severe weather <input type="checkbox"/> Other event that threatened the immediate health and safety of a person <input type="checkbox"/> Natural disaster
Response	<input type="checkbox"/> Calling 911 <input type="checkbox"/> Moving to an emergency shelter <input type="checkbox"/> Emergency evacuation <input type="checkbox"/> Temporary closure or relocation of a program for more than 24 hours

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.

Description of Staff Response to the Emergency	
<input type="checkbox"/> Applicable coordinated service and support plan addendum(s) were implemented for person(s) involved. <input type="checkbox"/> Applicable program policies and procedures were implemented as written.	
Staff person(s) who responded to the emergency	_____ _____ _____

Name of staff completing this form – please print

Signature _____
Date

Internal Review	
Was the emergency similar to past events with the persons, staff, or the services involved?	
<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, identify the patterns, if any, below
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?	
<input type="checkbox"/> yes <input type="checkbox"/> 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 of staff completing internal review – please print

Signature _____
Date