STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

DATE COMPLETED:

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information [Ombudsman use only - WIC 15636(a)]

*NAME (LAST NAME FIRST) | *AGE | DATE OF BIRTH | SSN | GENDER ☐ M ☐ F | ETHNICITY | LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (*SPECIFY*)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN) | *CITY | *ZIP CODE | *TELEPHONE

*PRESENT LOCATION (IF DIFFERENT FROM ABOVE) | *CITY | *ZIP CODE | *TELEPHONE

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABL ☐ ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES ALONE ☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ *Check if* ☐ *Self-Neglect*

NAME OF SUSPECTED ABUSER

☐ CARE CUSTODIAN (type)_____ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER_____

☐ HEALTH PRACTITIONER (type) _____ ☐ SPOUSE ☐ OTHER RELATION_____

ADDRESS | *ZIP CODE | TELEPHONE | GENDER ☐ M ☐ F | ETHNICITY | AGE | D.O.B. | HEIGHT | WEIGHT | EYES | HAIR

C. REPORTING PARTY: *Check appropriate box if reporting party waives confidentiality to:* ☐ ✓ All ☐ ✓ All but victim ☐ ✓ All but perpetrator

*NAME (PRINT) | SIGNATURE | OCCUPATION | AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW KNOWS OF ABUSE | (STREET) | (CITY) | (ZIP CODE) | (E-MAIL ADDRESS) | TELEPHONE

D. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)

☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL

☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL
- ☐ ASSAULT/BATTERY
- ☐ CONSTRAINT OR DEPRIVATION
- ☐ SEXUAL ASSAULT
- ☐ CHEMICAL RESTRAINT
- ☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION
f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).* ☐ ✓CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS): | TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER | TRUST ACCOUNT: ☐ YES ☐ NO

POWER OF ATTORNEY: ☐ YES ☐ NO | DIRECT DEPOSIT: ☐ YES ☐ NO | OTHER ACCOUNTS: ☐ YES ☐ NO

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(family, significant others, neighbors, medical providers and agencies involved, etc.)*

NAME | ADDRESS | TELEPHONE NO. | RELATIONSHIP

I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME | IF CONTACT PERSON ONLY ✓ CHECK ☐ | *RELATIONSHIP

*ADDRESS | *CITY | *ZIP CODE | *TELEPHONE

J. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE | *TELEPHONE | DATE/TIME

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

AGENCY NAME | ADDRESS OR FAX # | ☐ Date Mailed: ☐ Date Faxed:

L. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:
2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

   Approved by: Assigned to (optional):
3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:
4. APS/Ombudsman/Law Enforcement Case File Number:_____