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 this 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/DISABLED ☐ 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 RELATIONSHIP ____

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: ____