REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

Date Completed

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

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 Name)	Age	Date of Birth	SSN

Gender Identity	Sexual Orientation	Ethnicity	Race
☐ Male ☐ Female ☐ Transgender ☐ Other/Nonbinary ☐ Unknown/Not Provided	☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Questioning ☐ Unknown/Not Provided		

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)			

☐ Elderly (60+) ☐ 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

Address	City	Zip Code	Telephone

☐ Care Custodian (Type)_____ ☐ Parent ☐ Son/Daughter ☐ Other _____
☐ Health Practitioner (Type)_____ ☐ Spouse ☐ Other Relation _____

Gender ☐ Male ☐Female	Ethnicity	Age	D.O.B

Height	Weight	Eyes	Hair

C. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? DOES THE ALLEGATION INVOLVE A SERIOUS BODILY INJURY (see definition in section "Reporting Responsibilities and Time Frames" within the General Instructions)? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.) or concerns about the client's mental health.

☐ CHECK IF MEDICAL, FINANCIAL (ACCOUNT INFORMATION, ETC.), PHOTOGRAPHS, OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

D. REPORTING PARTY Check appropriate box if reporting party waives confidentiality to
☐ All ☐ All but victim ☐ All but perpetrator

Name	Signature	Occupation	Agency/Name of Business

Relation to Victim/How Abuse is Known	Street	City	Zip Code

Telephone	E-mail Address

E. 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)_____

F. REPORTED TYPES OF ABUSE (Check All that Apply)

1. Perpetrated by Others (WIC 15610.07 & 15610.63)

a. ☐ Physical (e.g. assault/battery, constraint or deprivation, chemical restraint, over/under medication)
b. ☐ Sexual
c. ☐ Financial
d. ☐ Neglect (including Deprivation of Goods and Services by a Care Custodian)
e. ☐ Abandonment
f. ☐ Isolation
g. ☐ Abduction
h. ☐ Psychological/Mental
i. ☐ Other _____

2. Self-Neglect (WIC 15610.57 (b)(5))

a. ☐ Neglect of Physical Care (e.g. personal hygiene, food, clothing, malnutrition/dehydration)
b. ☐ Self-Neglect of Residence (unsafe environment)
c. ☐ Financial Self-Neglect (e.g. inability to manage one's own personal finances)

Abuse Resulted In (Check All that Apply)

☐ No Physical Injury ☐ Minor Medical Care ☐ Hospitalization ☐ Care Provider Required
☐ Death ☐ Mental Suffering ☐ Serious Bodily Injury* ☐ Other (Specify)_____
☐ Unknown ☐ Health & Safety Endangered

G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE
(Family, significant others, neighbors, medical providers, agencies involved, etc.)

Name	Relationship
Address	Telephone
Name	Relationship
Address	Telephone

H. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE
(If known, list contact person) If Contact person check ☐

Name			Relationship
Address	City	Zip Code	Telephone

I. TELEPHONE REPORT MADE TO ☐ APS ☐ Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of State Hospitals ☐ Calif. Dept. of Developmental Services

Name of Official Contacted by Phone	Telephone	Date/Time

J. WRITTEN REPORT Enter information about the agencies receiving this report. If the abuse occurred in a LTC facility and resulted in Serious Bodily Injury*, please refer to "Reporting Responsibilities and Time Frames" in the General Instructions. Do not submit report to California Department of Social Services Adult Programs Division.

Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed
Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed
Agency Name	Address or Fax	☐ Date Mailed	☐ Date Faxed

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

1. Report Received By Date/Time

2. Assigned ☐ Immediate Response ☐ Ten-Day Response ☐ No Initial Response (NIR)
☐ Not APS ☐ Not Ombudsman ☐ No Ten-Day (NTD)

Approved By Assigned To (optional)

EFFECTIVE: 06-01-00 REVISED: 04-01-23 SUPERSEDES: 04-01-21

3. Cross-Reported to ☐ CDPH-Licensing & Cert.; ☐ CDSS-CCL; ☐ Local Ombudsman;
☐ Bureau of Medi-Cal Fraud & Elder Abuse;
☐ Calif. Dept. of State Hospitals; ☐ Law Enforcement;
☐ Professional Licensing Board; ☐ Calif. Dept. of Developmental Services;
☐ APS; ☐ Other (Specify) _____
Date of Cross-Report _____

4. APS/Ombudsman/Law Enforcement Case File Number