

Dependent Adult Abuse Intake

Referral Date / Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Report Due 20 days	Worker	Registry Number
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Dependent Adult

First Name		M	Last	
County	Telephone (Home)		(Other)	
Household Address		City	State	Zip
Directions to Home				
Address of Abuse Incident				
R	S	DOB	Social Security Number	

Assessment of Dependency

A. Is there a diagnosed physical/mental condition? Yes No Unknown
 Explain:

B. Does adult have adequate decision-making ability?
 Yes No Sometimes Unknown
 Explain:

C. Does the adult require assistance in the following tasks of daily living?
 Cooking Cleaning Finances Hygiene Mobility
 Dressing Supervision Medical care Other:
 Explain:

Caretaker/Person Reported as Responsible for Abuse Dependent adult is responsible for the abuse

First Name	M	Last			Relationship
Address		City	State	Zip	Telephone
R	S	DOB	Social Security Number		

Assessment of Caretaker

- A. Type of caretaker: Voluntary assumption of services Court ordered
 Contractual relationship Unknown
- B. Impact of caretaker services: Essential to meet basic needs
 Adult would suffer harm if services discontinued

Allegations

Evaluation – There is a caretaker.

-
- Physical
-
- Critical care
-
-
- Sexual
-
- Exploitation

Assessment – There is no caretaker.

-
- Critical care due to adult's actions
-
-
- Sexual exploitation

Summary of allegations:

Barriers

-
- Language
-
- Lack of services
-
- Isolation
-
- None
-
-
- Other (explain):

Collateral Sources of Information

Name	Relationship	Address	Telephone
Name of Guardian, Conservator or Other Person Responsible for Dependent Adult			
Address		City	State Zip Telephone

Reporter Information

Reporter Name & Title		Agency		
Relationship to DA	Address	City	State	Zip
Telephone Number (W) (H)	<input type="checkbox"/> Mandatory: <input type="checkbox"/> Mandatory, Reporter Permissive		<input type="checkbox"/> Permissive	

Central Registry and Background Check

Registry Contact Date	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Intake Decision Date / Time	Supv. Initials
<input type="checkbox"/> Accept		<input type="checkbox"/> Reject – Reason:	
Dependent Adult:	<input type="checkbox"/> DAA	<input type="checkbox"/> ISIS	<input type="checkbox"/> Criminal
Person Suspected of Abuse:	<input type="checkbox"/> DAA	<input type="checkbox"/> Criminal	
Worker Assigned			Worker Number

Additional Information

Double click to activate buttons.

Add or Remove Worker Safety Alert

Send Form