# **North Carolina Department of Health and Human Services**

#  **Adult Services**

##### **Adult Protective Services Intake**

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|  1. AGENCY INFORMATION  |
| A. Date of Report: | B. Time: |
| C. Intake Worker: | D. How Received: |
| E. SIS ID Number: | F. County Case #: |
| G. APS/Intake #: | H. Social Security #: |
| 2. ADULT AND FAMILY INFORMATION |
| A. Last Name of Adult | B. First | C. Middle Initial | D. Alias | E. Family’s Primary Language  |
| F. Date of Birth | G**.** Age | H. Gender[ ]  Female[ ]  Male | I. Race | J. Marital Status[ ] Divorced [ ]  Married/Separated [ ]  Single[ ]  Widowed [ ]  Other  |
| Residence Information |
| K. Residence Address  | L. Residence Telephone Number |
| M. Length of Stay at Residence Address |
| N. Residence Living Arrangement/Facility Name | O. County (Of Adult’s Residence) |
| **Current Location Information** |
| P. Address of Current Location if Different Than Residence Address | Q. Telephone Number of Current Location |
| R. Length of Stay at this Address |
| S. Current Living Arrangement | T. County (Where the Adult is Located) |
| U. Driving Directions to Current Location/Residence |
| V. Others in Residence/LocationName | Relationship to Adult | Age  | Residence or Location |
| 3. ABUSE/NEGLECT/EXPLOITATION |
| A. What happened to make you call today? |
| B. In what way do you think the adult is abused, neglected, or exploited; is self-neglecting; or is at risk of abuse, neglect or exploitation?  |
| C. Is there a specific individual(s) who mistreated the adult? [ ]  Yes [ ]  No [ ]  Unknown If yes, complete the following: |
| Name | Relationship | Telephone Number/Address/Current Location |
| D. If allegations indicate specific event(s), when did this happen?  | E. Where did this happen?  |
| F. How long has this been going on?  | G. When did you last see the adult?  |
| H. Has this situation caused harm to the adult? [ ] Yes [ ] No [ ] Unknown If yes, explain.  |
| I. How has the adult’s physical/mental health and functioning declined or changed?  |
| J. Is the adult possibly in immediate danger of death? [ ] Yes [ ] No [ ] Unknown If yes, describe the danger.  |
| K. Is the adult at risk of irreparable harm? [ ] Yes [ ] No [ ] Unknown If yes, describe the danger.  |
| L. Did you witness the incident or condition? [ ] Yes [ ] No If not, how did you become aware of the situation?  |
| M. Is the adult aware of this report? [ ] Yes [ ] No [ ] UnknownIf yes, what is his/her reaction?  | N. Is the family aware of the report? [ ] Yes [ ] No [ ] UnknownIf yes, who?  |
| O. Is there someone who might have additional knowledge regarding the adult’s situation? [ ] Yes [ ] No [ ] Unknown Do they see a doctor? [ ]  Yes [ ]  No [ ]  Unknown If yes to either, provide: |
| Name | Relationship | Telephone Number |
| P. Has the adult or the family been involved with DSS before? [ ]  Yes [ ]  No [ ]  Unknown If yes, explain.  |
| Q. Do you know if other reports have been made about the adult/family? [ ]  Yes [ ]  No [ ]  Unknown If yes, give details.  |
| R. Do you know if law enforcement has been involved? [ ]  Yes [ ]  No [ ]  Unknown If yes, give details.  |
| 4. RISK FACTORS OF ABUSE, NEGLECT, OR EXPLOITATION |
| A. Are there other conditions or circumstances that put the adult at risk of abuse, neglect, or exploitation? If yes, check below and explain: |
|  |
| Yes | No | Reporter Doesn’t Know |  |  |
| **[ ]**  | **[ ]**  | **[ ]**  | Fire Hazards | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Structural Damage | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Vermin/Pests | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Inadequate Heating/Cooling | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Inappropriately Cared for Pets or Animals | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Falling/Tripping Hazards | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | No Access to Transportation | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | No Telephone Access | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | External Environmental Hazards | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Bills Not Being Paid | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Basic Needs Not Met/Income Not Sufficient | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Lends Money/Support Others Financially | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Missing Property/Assets/Banking Irregularities | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Substantial Debt | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Limited Social Contacts (Family, Friends, Church, Etc.) | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Recent Losses | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Other | Explain  |
| **5. DISABILITY ALLEGATIONS** |
| Describe the adult’s physical and/or mental problems.  (Ask the reporter to share information he/she has regarding the adult’s problems. Does the adult take any medicines? [ ]  Yes [ ]  No [ ]  Unknown Do they have a specific illness or diagnosis?)  |
| Check physical and/or mental problems below and explain: |
| Yes | No | Reporter Doesn’t Know |  |  |
| **[ ]**  | **[ ]**  | **[ ]**  | Short Term Memory Loss/Signs of Confusion/Wandering/Impaired Judgment | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Inappropriate Behaviors/Combative Behavior | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Visual or Auditory Hallucinations | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Substance Abuse | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Recent Suicide Attempts | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Fearful or Anxious/Seems Sad Withdrawn/Cries | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Difficulty Ambulating/Recent Falls | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Confined to Bed | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Sensory Impairments | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Skin Problems | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Weight Loss or Gain/Malnourished | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Continence Problems | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Other | Explain  |
| B. Describe how the adult is limited in performing activities and/or obtaining services necessary for daily living.  |
| Review and check strengths below and explain any limitations: |
| Yes | No | Reporter doesn’t know |  |  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Bathe Self | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Dress Self | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Manage Basic Hygiene/Grooming/Toileting | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Feed Self | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Transfer | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Prepare Meals | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Administer Medication | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Do Laundry | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Do House-Keeping/Laundry | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Repair Home From Structural Damage/Home Maintenance | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Use Telephone | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Able to Manage Money | Explain  |
| **[ ]**  | **[ ]**  | **[ ]**  | Other | Explain  |
| 6 CARETAKER  |
| A. Is there anyone who helps the adult on a regular basis? [ ]  Yes [ ]  No [ ]  Unknown If yes, provide the following information: |
| Name | Relationship | What do they do? How often? |
| B. Has any one of the above individuals assumed the responsibility for the adult’s day-to-day well-being? [ ] Yes [ ] No [ ] Unknown If yes, who and explain.  |
| C. Does someone help with the decision-making? [ ] Yes [ ] No [ ] Unknown If yes, who and describe role (i.e. POA, Legal Guardian, etc.).  |
| D. Are they aware of the situation? [ ] Yes [ ] No [ ]  Unknown If no, explain.  |
| E. Is someone managing the adult’s finances? [ ] Yes [ ] No [ ] Unknown If yes, explain.  |
| 7. NEED FOR PROTECTION |
| Has anyone attempted to stop what is happening to the adult? [ ] Yes [ ] No [ ] Unknown If yes, explain what they have done.  |
| 8. SAFETY ISSUES |
| Are there any environmental or safety issues that the worker should be aware of? [ ] Yes [ ] No [ ] Unknown If yes, explain.  |
| 9. REPORTER INFORMATION |
| A. Is this an anonymous report?[ ] Yes [ ] No  | B. Reporter’s Last Name | C. First  | D. Relationship to adult |
| E. Address | F. Telephone Number | G. How does the reporter wish to be notified? |
| 10. INTAKE SIGN-OFF |
| Criteria Explained **[ ]**  | Confidentiality of Reporter Information Explained **[ ]**  | Notice to Reporter Requirements Explained **[ ]**  |
| Intake Worker Signature APS  | Date Time  |
| 11. DISPOSITION OF REPORT (FOR SUPERVISORY SCREENING USE ONLY) |
| A. Is the adult alleged to be disabled? [ ] Yes [ ] No  |
| B. Is the adult alleged to be abused, neglected, or exploited? [ ] Yes [ ] No Check all that apply:[ ]  Abuse [ ]  Self Neglect [ ]  Caretaker Neglect [ ]  Person Exploitation [ ]  Assets Exploitation |
| C. 1. Is there someone willing, able, and responsible to provide or obtain essential services? [ ] Yes [ ] No  2. Is the adult able, willing, and responsible to obtain essential services? [ ] Yes [ ] No  3. Is the adult alleged to be in need of protective services? [ ] Yes [ ] No  |
| D. 1. Is the adult a resident of another NC county? Yes [ ]  No [ ]  If yes, which county? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. County of Residence Supervisor or designee informed Yes [ ]  No[ ]   If yes, date and time: [ ]  Yes No [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Supervisor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Supervisor Phone/Fax/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Date APS Intake report sent to County of Residence. [ ]  Yes [ ]  No Date and time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. County of Residence Confirmed receipt Yes [ ]  No [ ]  If yes date and time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Confirmed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. APS Case will be initiated by: County of Residence [ ]  County of Location [ ]  |
| E. Supervisor Comments:  |
|  |
| F. **[ ]**  Report accepted for evaluation **[ ]**  Outreach **[ ]**  Information & Referral |
| G. Initiation Response Time **[ ]**  Immediate (If the complainant alleges danger of death) **[ ]**  24 Hours (If the complainant alleges danger of irreparable harm) **[ ]**  72 Hours (if the complainant does not allege danger of death or irreparable harm) |
| H. Assigned Social Worker: |
| I. Supervisor Signature Date Time  | J. Secondary Screener Signature Date Time  |
|  K. **[ ]**  Report not accepted for evaluation. If not, explain which of the criteria were not met.  |
| L. Notification (Check any notifications that are needed) **[ ]**  District Attorney **[ ]**  Law Enforcement **[ ]**  Div. of Health Service Regulation  **[ ]**  Adult Home Specialist **[ ]**  Reporter Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| M. Referrals 1. Referral Information Given to Reporter for Community Service: [ ] Yes [ ] No If yes, list agencies.
2. In-House Referrals Made.[ ] Yes [ ] No If yes, list unit or department, information provided, and expected follow-up.
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