

North Carolina Department of Health and Human Services Adult Services Community Evaluation

IDENTIFYING INFORMATION

County Case #:

SIS 11 Digit #:

Last Name	First Name	Middle Initial	Alias
Date of Birth	Age	Gender	Race
		Choose	Choose

Social Security #:

Family Primary Language: English Spanish Other

Marital Status: Single Married Divorced Domestic Partner Separated Widowed

Telephone Number: **Telephone number of current location:**

Current Living Arrangement: Choose Length of stay at this address:

Address or driving directions:

Address of Current Living Arrangement, if different from residence address:

Length of stay at current location:

Education Level (highest level completed): Choose

Able to read? Yes No Able to write? Yes No

History of APS reports? Yes No

If yes, provide dates of previous APS reports (Within last two years)

Click or tap to enter a date.
Click or tap to enter a date.
Click or tap to enter a date.
Click or tap to enter a date.

Were photos taken? Yes No If, yes, provide location of photos in record:

Same perpetrator? Yes No

Religious preference: Choose

Special Considerations (e.g. cultural, religious, speaks foreign language, deaf, visually impaired, etc.):

History of Reports:

	Date	Time	AM	PM	
Date of the Report			<input type="checkbox"/>	<input type="checkbox"/>	
Report was initiated			<input type="checkbox"/>	<input type="checkbox"/>	
First face to face contact with adult			<input type="checkbox"/>	<input type="checkbox"/>	
First private interview with adult			<input type="checkbox"/>	<input type="checkbox"/>	
Initial notice to reporter			<input type="checkbox"/>	<input type="checkbox"/>	Written <input type="checkbox"/> Verbal <input type="checkbox"/>
Final notice to reporter			<input type="checkbox"/>	<input type="checkbox"/>	Written <input type="checkbox"/> Verbal <input type="checkbox"/>
Date of case decision			<input type="checkbox"/>	<input type="checkbox"/>	
Dates of required notices (as needed)			<input type="checkbox"/>	<input type="checkbox"/>	DA
Dates of required notices (as needed)			<input type="checkbox"/>	<input type="checkbox"/>	LE
Dates of required notices (as needed)			<input type="checkbox"/>	<input type="checkbox"/>	DHSR <input type="checkbox"/> Administrator <input type="checkbox"/>
Dates of other notices (as needed)			<input type="checkbox"/>	<input type="checkbox"/>	DMA <input type="checkbox"/> AHS <input type="checkbox"/>
5026 completed and submitted			<input type="checkbox"/>	<input type="checkbox"/>	
5027 completed for 202 services			<input type="checkbox"/>	<input type="checkbox"/>	

Type of alleged maltreatment:

- Abuse causing pain/injury
- Abuse
- Caretaker neglect
- Self neglect
- Exploitation of person's assets
- Exploitation of person
- Other

At substantial risk: Yes No Specify type below:

Summary of Allegations:

Were there any problems accessing the adult? Yes No

If yes, document dates of attempts to see the adult and describe problems and efforts taken to resolve.

Dates	Efforts to resolve explained below
Click or tap to enter a date.	
Click or tap to enter a date.	
Click or tap to enter a date.	
Click or tap to enter a date.	

Did a life-threatening situation exist? Yes No

If yes, describe situation and action(s) taken to address the danger:

SOCIAL SUPPORT

Household composition

Names	Age	Relationship	Assistance Provided

Family and significant others outside the home (friends, neighbors, church, etc.)

Names	Age	Relationship	Type/Frequency of Contact

Ask the following questions to assess caretaker support status

When there is a problem who do you call first?	
Who is helping you now and what do they do?	
How do you contact them?	
How do you feel about what and how much your helpers are doing?	
How do you think they feel?	
Who do you come in contact with on a typical day?	
Do you receive any help from any community agencies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the agency and who is your contact person?	

Community Agency Information

Agency	Contact person	Service(s) provided

Based on the above information, does the adult have a caretaker? Yes No

A caretaker is one who has the comprehensive hands on day-to-day responsibility of the disabled adult.

If yes, give the following applicable information about the primary caretaker.

Name	
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Address	
Relationship to the adult	
Contact number	

Is the caretaker any of the following:

Date of appointment/authority given:

<input type="checkbox"/> Legal Guardian	Click or tap to enter a date.
<input type="checkbox"/> Guardian of Person	Click or tap to enter a date.
<input type="checkbox"/> Guardian of Estate	Click or tap to enter a date.
Power of Attorney (Identify type)	Registered in: <input type="checkbox"/> County <input type="checkbox"/> State
<input type="checkbox"/> General	Click or tap to enter a date.
<input type="checkbox"/> Durable	Click or tap to enter a date.
<input type="checkbox"/> Health care	Click or tap to enter a date.
<input type="checkbox"/> Representative Payee for	Click or tap to enter a date.
<input type="checkbox"/> Living Will	Click or tap to enter a date.

If someone else other than the primary caretaker has legal guardianship, power of attorney, payee for the adult, or other caretaking responsibility, list their name, address, telephone number and type of authority/responsibility below:

Name	Address	Telephone number	Type authority

The following are indicators of maltreatment. The presence of these “red flags” indicate a high-risk of maltreatment and require that information is needed to determine the effect it has on the adult’s safety. N/A if there is no caretaker.

Caretaker Indicators

If yes, impact on adult

Alcohol/drug misuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental/emotional impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Financially dependent on adult	<input type="checkbox"/> Yes <input type="checkbox"/> No	
No contacts outside the home	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blaming the adult/hypercritical	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deterioration of physical health	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reluctance to provide care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Inexperienced/unrealistic expectations of adult/self	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family Systems Indicators

If yes, impact on adult

Lack of family support	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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Disagreement over shared responsibility	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
History of violence in handling stress or conflict	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Economic, financial problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Overcrowding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Marital conflict	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Intergenerational conflict	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Comments:

ENVIRONMENTAL

Adult's living arrangement:

Type of residence:

If other, specify below:

Environmental Risk Factors (Check all that apply)

<input type="checkbox"/> Threatened eviction	<input type="checkbox"/> No electricity	<input type="checkbox"/> Household areas inaccessible
<input type="checkbox"/> Inadequate heating/cooling source	<input type="checkbox"/> Accumulated debris	<input type="checkbox"/> No safe water supply
<input type="checkbox"/> Deteriorating structure	<input type="checkbox"/> No water	<input type="checkbox"/> Unsanitary conditions
<input type="checkbox"/> Neighborhood	<input type="checkbox"/> Animal infested living quarters	<input type="checkbox"/> Telephone
<input type="checkbox"/> Accessibility issues	<input type="checkbox"/> No food storage facilities	<input type="checkbox"/> Transportation
<input type="checkbox"/> Mobility barriers	<input type="checkbox"/> Fire hazards	<input type="checkbox"/> Internal hazards
<input type="checkbox"/> External hazards	<input type="checkbox"/> Inadequate toilet facilities	<input type="checkbox"/> Others please specify below:
<input type="checkbox"/> Insect infested living quarters		

Level of Endangerment

<input type="checkbox"/> Immediate life threat	<input type="checkbox"/> No evident danger
<input type="checkbox"/> Potential of serious harm	<input type="checkbox"/> Adult understands
<input type="checkbox"/> At substantial risk	<input type="checkbox"/> Adult does not understand
<input type="checkbox"/> Adult unwilling to accept assistance	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Adult willing to accept assistance	

Comments/Description (if needed):

Does the home have a working smoke detector? Yes No

Describe any environmental risk factors and the adult's understanding of risk factors:

ECONOMIC ASSESSMENT

Adult's financial affairs are managed by:

DHHS-AS-0005
(Rev.03/2024) Adult
Services

Self	Other: Name/relationship

Monthly Income		Monthly Expenses		Benefits Received
Social Security		Rent		<input type="checkbox"/> Medicare Part A
SSI		Mortgage		<input type="checkbox"/> Medicare Part B
VA Pension		Utilities		<input type="checkbox"/> Medicaid
RR Retirement		Taxes		<input type="checkbox"/> Other Health Insurance
Public assistance		Medicine		<input type="checkbox"/> FNS \$
Interest/dividends		Life insurance		
Pension		Health insurance		
Retirement		Medical expenses		
Other:		Other:		
Total		Total		

Assets

Assets	Value	Description/location if known
Checking account		
Savings account		
Real estate		
Securities		
Personal		
Other:		

Does the adult experience financial problems in meeting basic needs such as: (check all that apply)

<input type="checkbox"/> Food	<input type="checkbox"/> Power	<input type="checkbox"/> Fuel
<input type="checkbox"/> Shelter	<input type="checkbox"/> Medicine	<input type="checkbox"/> Clothing
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other

Adult/Family's perception of adult's financial situation and ability to manage finances:

MENTAL/EMOTIONAL FUNCTIONING

Orientation

Complete the following questions to review the adult's orientation.

Time:	Does the adult know the correct day of the week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Non-Responsive	<input type="checkbox"/> Refused to Answer
	Does the adult know the correct month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Non-Responsive	<input type="checkbox"/> Refused to Answer

	Does the adult know the correct year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Non-Responsive	<input type="checkbox"/> Refused to Answer
Place:	Does the adult know the name of the facility where he/she is residing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Non-Responsive	<input type="checkbox"/> Refused to Answer
	Does the adult know in whose home he/she is residing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Non-Responsive	<input type="checkbox"/> Refused to Answer
Self:	Does the adult know his/her name?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Non-Responsive	<input type="checkbox"/> Refused to Answer
	Does the adult know his/her relationship to significant others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Non-Responsive	<input type="checkbox"/> Refused to Answer

Memory

Assess distant, recent and immediate memory. Resources to many of the other questions asked during the interview can be used to complete the rating. Enter one of the responses below on the line in front of each area.

1- Good	2- Some Loss of Detail	3- Total or Marked Impairment	4- Non-responsive	5- Refused to Answer
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	DISTANT: Discuss early events in the adult's life (e.g. childhood, date of birth, school, marriage, birth, of children) to assess distant memory
	RECENT: Discuss recent events (e.g., community/family events, doctor's visits, medical treatments, taking of medication) to access recent memory.
	IMMEDIATE: Assess immediate memory by returning to topics covered earlier (e.g. Did I remember to ask where you were born?) and in talking about what the client was doing earlier in the day.

Describe any memory impairments:

Judgment

Assess the clients' response to both routine and emergency situations. Enter one of the responses below.

- 1. Good decision-making/problems solving skills**
- 2. Mild deficient: can handle everyday decisions/problems, but not good with complex issues**
- 3. Moderate deficient: questionable decision-making/problem solving skills, may be able to handle some routine decisions**
- 4. Severe deficient; difficulty with some simple issues, cannot make decisions or solve problems**
- 5. Non-responsive**
- 6. Refused to answer**

_____ **Routine:** Describe several routine situations that may occur (e.g. light bulb burns out; cannot open medicine bottle; in-home aide does not come to the home; stranger knocks on the door; money is low and purchasing decisions must be made; cannot read medicine bottle instructions) and assess ability to gather and accept facts, weigh advice, solve problems, make decisions, and understand their consequences.

Additional information below:

_____ **Emergency:** Describe several emergency situations that may occur (e.g. power goes out; no money to buy food/medicine; client falls; house/appliance fire) and assess ability to gather and accept facts, weigh advice, discern unsafe/threatening situations, make decisions and understand their consequences.

Additional information below:

_____ **Arithmetic:** The adult's ability to handle simple arithmetic tasks provides an indication of mental function, may distinguish between depression and dementia, and is linked to the capacity to perform other tasks such as managing funds. Assessment of this area can be performed as part of other areas such as the assessment of economic status. The worker may also ask the client to perform simple tasks such as subtracting by twos from twenty. Enter one of the responses below to indicate the adult's arithmetic ability.

Additional information below:

1-Client can perform simple tasks with no or minimal errors	2-Client cannot perform simple tasks with reliable accuracy	3-Client non-responsive	4-Refused to answer
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Arithmetic Ability (Indicate arithmetic ability from chart above): _____

Mental/Emotional Assessment

Diagnosis/Symptom	*Source	Notes (e.g., onset, severity, functional impact, history, untreated conditions, needs professional assessment, current treatment)
Aggressive/abusive behavior		
Agitation/anxiety/panics attacks		
Change in activity levels (sudden/extreme)		
Change in appetite		
Cognitive impairment/memory impairment		
Intellectual and Developmental Disability (IDD)		
Hallucinations/delusions		
Inappropriate affect (flat or incongruent)		
Impaired judgement		
Mental anguish		
Mental illness		

Orientation impaired		
Persistent sadness		
Sleep disturbances		
Substance abuse		
Thoughts of death/suicide		
Wandering		
Other		

***Source Codes**

C=Client statement

M=FL2, MD, other medical professionals

F=Family member/guardian/responsible party

S=Social worker observation

O=Other – specify

Describe any memory impairment:

Activities of Daily Living (basic and instrumental)

ADL Tasks

Task	Needs Assistance	Provided by	Source Code
Ambulation			
Bathing			
Eating			
Grooming			
Toileting			
Transfer to/from bed			
Transfer to/from chair			
Transfer into/out car			

IADL Tasks

Task	Needs Assistance	Provided by	Source Code
Home maintenanc			
Housework			
Laundry			
Meal preparation			
Money management			
Shopping/errands			
Telephone use			
Transportation			

***Source Code**

C=Client Statement

M=FL-2, other medical

O=Other collateral

F= Family member/guardian/responsible party

S=Social worker

PHYSICAL HEALTH ASSESSMENT

DIAGNOSIS/SYMPTOMS	*Source Code	Notes (e.g., onset, severity, functional impact, history, untreated conditions, needs professional assessment, current treatment)
Arthritis/osteoporosis/gout	Choose	
Asthma/emphysema/other respiratory	Choose	

Bladder/urinary problems or incontinence	Choose	
Bowel problems or incontinence	Choose	
Cancer	Choose	
Dental problems	Choose	
Diabetes	Choose	
Dizziness/falls	Choose	
Eye disease	Choose	
Hypertension/high blood pressure	Choose	
Heart disease/angina	Choose	
Kidney disease/renal failure	Choose	
Liver disease	Choose	
Multiple sclerosis/muscular dystrophy/cerebral palsy	Choose	
Pain	Choose	
Paraplegia/quadruplegic/spinal problems	Choose	
Parkinson's Disease	Choose	
Rapid weight gain/loss	Choose	
Seizures	Choose	
Shortness of breath/persistent cough	Choose	
Skin condition	Choose	
Speech impairment	Choose	
Stroke	Choose	
Other	Choose	

***Source Code**

C=Client Statement

F= Family member/guardian/responsible party

O=Other collateral

M=FL-2, other medical

S=Social worker

Medical Treatment

Source/location of medical care and treatment	
Date of last medical visit	Click or tap to enter a date.
Date APS worker contacted medical provider	Click or tap to enter a date.
Physician name	

Findings:

Has adult recently been hospitalized? Yes No If yes, date of most recent hospitalization:

If yes, give reason for hospitalization below:

Able to take medication in prescribed doses at proper time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can prepare and take medications with reminder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can take medication if assisted with preparation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Refuses to take medications as prescribed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unable to take medications correctly without assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No

If adult needs assistance with medication, is he/she receiving assistance needed? Yes No

If yes, from whom?

If no, why is he/she not receiving the medication assistance?

Collateral Contact Information

Collateral contacts **MUST** be made with others who have pertinent information or knowledge of the adult's functioning and/or the allegations of mistreatment. Collaterals can include but are not limited to relatives, friends, neighbors, medical/mental health professionals, individuals who the adult mentions that may have pertinent information, law enforcement, etc. (Please add additional pages as needed.)

Date of Contact:	
Name of Collateral	
Relationship to Adult	
Address (Optional)	
Telephone Number	
Information Given	

Date of Contact:	
Name of Collateral	
Relationship to Adult	
Address (Optional)	
Telephone Number	
Information Given	

Date of Contact:	
Name of Collateral	
Relationship to Adult	
Address (Optional)	
Telephone Number	
Information Given	

Date of Contact:	
Name of Collateral	
Relationship to Adult	
Address (Optional)	
Telephone Number	

Information Given	
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Contact With Adult During APS Evaluation:

Date of Contact	Type Contact (e.g., HV, TC, OV)	Purpose of Contact	Others Present

Evidence of Abuse, Neglect or Exploitation or a Substantial Risk (*Substantial Risk is defined as allegations that do not indicate that a disabled adult has been, or is being abused, neglected, or exploited; but conditions exist that if not addressed may result in abuse, neglect or exploitation*).

<input type="checkbox"/> Hitting, slapping, or kicking	<input type="checkbox"/> Objects thrown at adult	<input type="checkbox"/> Demonstrates fear of the caretaker
<input type="checkbox"/> Broken bones or wounds	<input type="checkbox"/> Verbal assaults, threats	<input type="checkbox"/> Willful deprivation
<input type="checkbox"/> Multiple, severe bruises, burns or welts	<input type="checkbox"/> Prolonged interval between injury and treatment	
<input type="checkbox"/> Restrained, locked in, isolated	<input type="checkbox"/> Threatened/injured with weapon	
<input type="checkbox"/> Non-consenting sexual activity	<input type="checkbox"/> Injuries in odd places	

ABUSE BY CARETAKER – check all that apply

Level of Endangerment

<input type="checkbox"/> Immediate life threat	<input type="checkbox"/> No evident danger
<input type="checkbox"/> Potential of serious harm	<input type="checkbox"/> Adult understands
<input type="checkbox"/> At substantial risk	<input type="checkbox"/> Adult does not understand

<input type="checkbox"/> Adult unwilling to accept assistance	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Adult willing to accept assistance	

Comments/Description (if needed):

Neglect-check all conditions present

<input type="checkbox"/> Dirt, fleas, lice on person	<input type="checkbox"/> Inadequate clothing
<input type="checkbox"/> Malnourished or dehydrated	<input type="checkbox"/> Decayed teeth
<input type="checkbox"/> Fecal/urine smell	<input type="checkbox"/> Bedsore or other ulcers
<input type="checkbox"/> Doesn't get/take medications	<input type="checkbox"/> Lack of glasses/hearing aid or other prosthetic devices
<input type="checkbox"/> Medical/psychiatric needs	<input type="checkbox"/> Does not get to medical doctor
<input type="checkbox"/> Homeless	<input type="checkbox"/> No utilities (specify)
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Untreated medical needs: (specify)

Level of Endangerment

<input type="checkbox"/> Immediate life threat	<input type="checkbox"/> No evident danger
<input type="checkbox"/> Potential of serious harm	<input type="checkbox"/> Adult understands
<input type="checkbox"/> At substantial risk	<input type="checkbox"/> Adult does not understand
<input type="checkbox"/> Adult unwilling to accept assistance	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Adult willing to accept assistance	

Comments/Description (if needed)

Self Endangering Behaviors- check all that apply

<input type="checkbox"/> Suicidal acts	<input type="checkbox"/> Refuses medical treatment
<input type="checkbox"/> Self-inflicted injuries	<input type="checkbox"/> Threats of suicide
<input type="checkbox"/> Frequenting dangerous places	<input type="checkbox"/> Abuse of medications <input type="checkbox"/> RX <input type="checkbox"/> OTC
<input type="checkbox"/> Refuses MH treatment	<input type="checkbox"/> Refuses substance abuse treatment
<input type="checkbox"/> Wandering	<input type="checkbox"/> Denial of problems
<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Substance abuse	

Level of Endangerment

<input type="checkbox"/> Immediate life threat	<input type="checkbox"/> No evident danger
<input type="checkbox"/> Potential of serious harm	<input type="checkbox"/> Adult understands
<input type="checkbox"/> At substantial risk	<input type="checkbox"/> Adult does not understand
<input type="checkbox"/> Adult unwilling to accept assistance	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Adult willing to accept assistance	

Comments/Description (if needed)

Exploitation of Assets

<input type="checkbox"/> Unexplained disappearance of funds or valuables	<input type="checkbox"/> Chronic failure to pay for services and/or bills
<input type="checkbox"/> Excessive payment for care and/or services	<input type="checkbox"/> Transfer of other assets
<input type="checkbox"/> Transfer of real property	<input type="checkbox"/> Changes in Payee or Power of Attorney
<input type="checkbox"/> Sudden appearance of previously uncaring relatives or friends	<input type="checkbox"/> Inappropriate use of adult's telephone, food or other resources
<input type="checkbox"/> Significant debt	<input type="checkbox"/> Parasitic relationship of others toward adult
<input type="checkbox"/> Caretaker refuses to use adult's funds to meet essential needs	<input type="checkbox"/> Adult unaware of income amount
<input type="checkbox"/> Depleted bank account	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Other:	

Level of Endangerment

<input type="checkbox"/> Immediate life threat	<input type="checkbox"/> No evident danger
<input type="checkbox"/> Potential of serious harm	<input type="checkbox"/> Adult understands
<input type="checkbox"/> At substantial risk	<input type="checkbox"/> Adult does not understand
<input type="checkbox"/> Adult unwilling to accept assistance	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Adult willing to accept assistance	

Comments/Description (if needed):

Exploitation of the Person

<input type="checkbox"/> Forced to work without pay	<input type="checkbox"/> Sexual exploitation	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Other (specify)		

Level of Endangerment

<input type="checkbox"/> Immediate life threat	<input type="checkbox"/> No evident danger
<input type="checkbox"/> Potential of serious harm	<input type="checkbox"/> Adult understands
<input type="checkbox"/> At substantial risk	<input type="checkbox"/> Adult does not understand
<input type="checkbox"/> Adult unwilling to accept assistance	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Adult willing to accept assistance	

Comments/Description (if needed):

Summary of adult's understanding and willingness to accept assistance as indicated above:

Adult previously victimized? Yes No

Alleged Perpetrator Information

Current alleged perpetrator name		Date of birth	
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Address		Telephone number	
Relationship		Date of contact	

Alleged perpetrator’s contact with client:

Alleged perpetrator’s employment:

Alleged perpetrator’s reaction to APS worker:

Summary of perpetrator’s statement concerning APS allegations:

Criminal records checked (*optional*) Yes No Enter Date:

Relevant information obtained:

No contact made with perpetrator and reason:

RECOMMENDED SOCIAL WORK PRACTICE FOR MAKING A CASE DECISION:

1. Do not consider the disabled adult’s capacity to consent to APS at the case decision juncture, this may result in denying the victim access to APS.
2. Do not unsubstantiate the need for APS for the disabled adult due to a lack of a thorough evaluation, lack of staffing resources, lack of formal resources, lack of access to the court system, or prior history with the same victim who has historically refused APS services.
3. Do not unsubstantiate the need for APS for the disabled adult due to elements of the case decision being unclear; more information may need to be obtained.
4. Do not assume that because it appears that the disabled adult can perform an essential service but chooses not to, that they are in fact capable. There may be many reasons why a “seemingly” capable adult chooses to not act on their own behalf. “Learned Helplessness”, fear, and/or cognitive issues may be present.
5. Unless the social worker is reasonably assured that the identified “able, willing, and responsible” person will be able to act comprehensively on the adult’s behalf to provide essential services, the determination must be made that this person is not able, willing and responsible. Consider these questions:
 - a. Is the person physically capable and has the skill to provide or mobilize all protective services needed? Yes No
 - b. Is the person emotionally mature, trustworthy, reliable, and have a history of using good judgment and sound thinking? Yes No
 - c. Does this identified person understand the protective services needs and willing to make sure that all the needs are met? Yes No
 - d. Does the identified person have a physical or mental illness, substance abuse or other issues that may impact their ability to mobilize all protective services? Yes No

e. Are there any legal or relational issues between the identified person and the victim that may present as problematic, i.e., victim had been an abusive parent to identified person? Yes No

CASE FINDINGS

DISABLED ADULT:

An individual 18 years of age or a lawfully emancipated minor, present in North Carolina and has a disability that physically or mentally incapacitates them.

Is a Disabled Adult? Yes No Why or Why Not?

CARETAKER:

An individual who has the responsibility for the care of the disabled adult as a result of family relationship or who has assumed the responsibility for the care of the disabled adult voluntarily or by contract. A caretaker would have comprehensive responsibility for the adult's day-to-day well-being.

Has a caretaker? Yes No

ABUSE:

The willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or willful deprivation by a caretaker of services which are necessary to maintain mental and physical health.

Has been abused by their caretaker? Yes No If yes, state how:

NEGLECT:

A disabled adult who is either living alone and not able to provide for him/herself services which are necessary to maintain his mental or physical health, or is not receiving the services from his caretaker.

Has been neglected by their caretaker? Yes No If yes, state how:

Is self-neglectful? Yes No If yes, state how:

EXPLOITATION:

The illegal or improper use of a disabled adult or his resources for another's profit or advantage.

Has been exploited? Yes No If yes, state how:

IN NEED OF PROTECTIVE SERVICES:

A disabled adult shall be in need of protective services if that person, due to his physical or mental incapacity is unable to perform or obtain for himself essential services and if that person is without able, responsible, and willing persons to perform or obtain for him essential services.

Case Decision

Need for APS has been substantiated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Need for APS has been unsubstantiated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maltreatment confirmed but unsubstantiated	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the need for APS is substantiated, then complete Form #0010: Determination of Ability to Consent to Protective Services.

If services were offered and accepted, was DSS-5027 completed for APS Mobilization (204)?

Yes No

Date submitted:

SUBSTANTIAL RISK OF ABUSE, NEGLECT OR EXPLOITATION

Allegations do not indicate that a disabled adult has been or is being abused, neglected, or exploited but conditions exist, that if not addressed, may result in abuse, neglect, or exploitation.

Is a substantial risk <input type="checkbox"/> Yes <input type="checkbox"/> No	Services offered <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Accepted <input type="checkbox"/> Refused	Adult/Client referred to:
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Signature of APS Social Worker	Date
Signature of Supervisor	Date

SUMMARY

**(Additional notes or narrative should indicate which section of the evaluation it refers to.
May list agency staff involved in the case decision here.)**