

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

**IDENTIFYING INFORMATION**

**County Case #:** \_\_\_\_\_

**SIS 11 Digit #:** \_\_\_\_\_

<b>Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>	<b>Alias:</b>
<b>Date of Birth:</b>	<b>Age:</b>	<b>Gender:</b>	<b>Race:</b>
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:	<input type="checkbox"/> African- <input type="checkbox"/> American Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic Native <input type="checkbox"/> American <input type="checkbox"/> Other:

**Social Security #:** \_\_\_\_\_

**Family Primary Language:**  English  Spanish  Other:

**Marital Status:**  Single  Married  Divorced  Domestic Partner  Separated  Widowed

**Telephone #:** \_\_\_\_\_ **Telephone # of Current Location:** \_\_\_\_\_

Current Living Arrangement:  Owns home  Homeless  Shelter  Rental  
 Other \_\_\_\_\_

Length of stay at current location: \_\_\_\_\_

Address or driving directions:

Address of primary residence, if different from current living arrangement:

Education Level (highest Level completed)  High School Graduate  College Graduate  
 Advanced Degree.

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):

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

Same perpetrator?  Yes  No

Religious preference:  Catholic  Protestant  Non-denominational  Other

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

	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

Did a life-threatening situation exist?  Yes  No

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

**SOCIAL SUPPORT**

Household composition:

Name:	Age:	Relationship:	Assistance Provided:

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

Name:	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:

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

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

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

Name:	
Address:	
Relationship to the adult:	
Contact number:	

**Is the caretaker any of the following:**

Date of appointment given/authority given:

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

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 of 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.

<b>Caretaker Indicators:</b>			<b>If yes, impact on adult:</b>
Alcohol/drug misuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A	
Mental/emotional impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A	
Financially dependent on adult	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A	
No contacts outside the home	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A	
Blaming the adult/hypercritical	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A	
Deterioration of physical health	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A	
Reluctance to provide care	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A	
Inexperienced/unrealistic expectations of adult/self	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A	

<b>Family systems indicators:</b>			<b>If yes, impact on adult:</b>
Lack of family support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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 arrangements:**

Home                       Family                       Rents

**Type of residence:**

House             Boarding Room             Mobile Home             Apartment             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"/> Insect infested living quarters
<input type="checkbox"/> If others, 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):

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**

Adults financial affairs are managed by:

<input type="checkbox"/> Self	<input type="checkbox"/> 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:	
<b>Total:</b>	<b>Total:</b>	

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

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.

<b>Time:</b>	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
<b>Place:</b>	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
<b>Self:</b>	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

<b>1- Good</b>	<b>2- Some Loss of Detail</b>	<b>3- Total or Marked Impairment</b>	<b>4- Non-responsive</b>	<b>5- Refused to Answer</b>
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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 into 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, make decisions or solve problems, and understand their consequences.

Additional information here:

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

Additional information here:

**Arithmetic:**

The adult’s ability to handle simple arithmetic tasks provides and indication on mental functions may distinguish between depression and dementia and is linked to the capacity to perform other such 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 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.

<b>1-Client can perform simple tasks with no or minimal errors</b>	<b>2-Client cannot perform simple tasks with reliable accuracy</b>	<b>3-Client non-responsive</b>	<b>4-Refused to answer</b>
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**Arithmetic Ability** (Indicate arithmetic ability from chart above). \_\_\_\_\_

## Mental/Emotional Assessment

<b>Diagnosis/Symptom:</b>	<b>*Source Codes:</b> Listed below	<b>Notes:</b> (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

**F**=Family member/guardian/responsible party

**O**=Other – specify

**M**=FL2, MD, other medical professionals

**S**=Social worker observation

Describe any memory impairment:

**Activities of Daily Living (basic and instrumental)**

**ADL Tasks:**

<b>Task:</b>	<b>Needs Assistance:</b>	<b>Provided by:</b>	<b>*Source Codes:</b> Listed below
Ambulation			
Bathing			
Eating			
Grooming			
Toileting			
Transfer to/from bed			
Transfer to/from chair			
Transfer into/out car			

**IADL Tasks:**

<b>Task:</b>	<b>Needs Assistance:</b>	<b>Provided by:</b>	<b>* Source Codes:</b> Listed below
Home maintenance			
Housework			
Laundry			
Meal preparation			
Money management			
Shopping/errands			
Telephone use			
Transportation			

**\* Source Code**

**C**=Client Statement

**F**= Family member/guardian/responsible party

**O**=Other collateral

**M**=FL-2, other medical

**S**=Social worker

**PHYSICAL HEALTH ASSESSMENT**

<b>Diagnosis/Symptoms:</b>	<b>* Source Codes:</b> Listed below	<b>Notes:</b> (e.g., onset, severity, functional impact, history, untreated conditions, needs professional assessment, current treatment)
Arthritis/osteoporosis/gout		
Asthma/emphysema/other respiratory		
Bladder/urinary problems or incontinence		
Bowel problems or incontinence		

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

**\* 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:	
Date APS worker contacted medical provider:	
Physician name:	

**Findings:**

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

If yes, give reason for hospitalization below:

Medical records attached:  Yes  No

**Medications**

Name of Medication:	OTC:	Prescription/ Date filled:	Dosage/ Administration:	Prescribing MD:	Purpose:	Compliant:
	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No

**Note: Additional medications may be noted on added sheet.**

**Medication Assessment**

Can client identify prescribed medication and purposes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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, are they receiving assistance needed?  Yes     No

If yes, from whom?

If no, why are they 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:	

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

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 did not indicate that a disabled adult has been 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"/> Other:
<input type="checkbox"/> Not applicable	

**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?  One time  Several times over a short period of time  
 Many times over a long period of time  Unknown

**Alleged Perpetrator Information**

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

Alleged perpetrator's contact with client:  Daily  Weekly  Other

Alleged perpetrator's employment:

Alleged perpetrator's reaction to APS worker:  Cooperative  Refused to be interviewed

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 due to a lack of a thorough evaluation lack of staffing resources, lack of formal resources, lack of access to 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 does she/he have the skill to provide or mobilize all protective services needed?

Yes  No

b. Is the person emotionally mature, trustworthy, reliable, and does he/she 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 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 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 either living alone and not able to provide for him/herself services which are necessary to maintain his/her 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/her physical or mental incapacity, is unable to perform or obtain for him/herself essential services and if that person is without an able, responsible and willing person to perform or obtain 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 substantiated, then complete: A Determination of Ability to Consent to Protective Services.

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.

Adult is a substantial risk	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Services offered	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	<input type="checkbox"/> No <input type="checkbox"/> Accepted

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	Client referred to:
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<b>Signature of APS Social Worker</b>	<b>Date</b>
<b>Signature of Supervisor</b>	<b>Date</b>

## **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.)**