

NC OAASIS – DHHS-AS-5026 Adult Protective Services-Registry (APS-R) – Client Entry Form

The County Staff user enters the information in NC OAASIS, and it must be reviewed and approved for accuracy by a County Supervisor user or designated DSS leader with the County Supervisor role. Once approved, the form becomes active in the system and is considered officially reviewed and approved by DSS.

Fields marked with an asterisk (*) are required.

Client Identification

*County Name:	
*CNDS ID:	
*Client First Name:	*Client DOB:
*Client Last Name:	

Case Manager Section

*Client SIS ID:	County Case Number:
*Case Manager First Name:	Case Manager Middle Initial:
*Case Manager Last Name:	

Report Section

* Date of Report:	* Time of Report: <input type="checkbox"/> AM <input type="checkbox"/> PM
* Sources of Report (select all that apply): <input type="checkbox"/> Non-Relative <input type="checkbox"/> Relative <input type="checkbox"/> Mental Health Agency <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Health Department <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Aging Agency <input type="checkbox"/> Hospital/Physician <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Adult Care Home <input type="checkbox"/> DSS <input type="checkbox"/> Other Local Agency: <input type="checkbox"/> Self <input type="checkbox"/> Anonymous <input type="checkbox"/> Banks and other Financial Institutions <input type="checkbox"/> DHHS <input type="checkbox"/> Other State Agency:	* Types of Mistreatment Reported (select all that apply). When a caregiver (including a guardian) is present, select caretaker neglect; when no caregiver is involved, select self-neglect. Both cannot be selected. <input type="checkbox"/> Abuse – Causing pain or injury <input type="checkbox"/> Abuse – Other: <input type="checkbox"/> Self Neglect <input type="checkbox"/> Caretaker Neglect <input type="checkbox"/> Exploitation of the Person <input type="checkbox"/> Exploitation of Assets
* Adult Legal Status:	* Timeframe:
*Date Evaluation Initiated:	*Has there been a previous APS report evaluated involving the adult within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Time Evaluation Initiated: <input type="checkbox"/> AM <input type="checkbox"/> PM	*If yes, enter the date of the prior report:

Evaluation Section

* Medicaid Home and Community Based Services Waiver Participation:	* Completed as a conflict of interest? <input type="checkbox"/> Yes <input type="checkbox"/> No * Misuse of opioids by the Caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
* Misuse of opioids by the Adult: <input type="checkbox"/> Yes <input type="checkbox"/> No	* Marital status: <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other:
* Number of face-to-face visits with the Adult during the APS Evaluation:	
* Including the Adult, how many are in the household?	* Type(s) of disability: <input type="checkbox"/> Alzheimer's Disease/Other Related Disorders <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Epilepsy <input type="checkbox"/> Autism <input type="checkbox"/> Intellectual Developmental Disability (IDD) <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical Illness <input type="checkbox"/> Substance Use <input type="checkbox"/> Traumatic Brain Injury (TBI) <input type="checkbox"/> Mental Impairment <input type="checkbox"/> No Disability <input type="checkbox"/> Unknown <input type="checkbox"/> Other:
* Others in household: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> Other Relative(s) <input type="checkbox"/> Non-relative (Caretaker) <input type="checkbox"/> Non-relative (Non-Caretaker) <input type="checkbox"/> None	
* Military status: <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> None of the above	

<p>* Employment status:</p>	<p>* Where was the Adult living at the conclusion of the APS Evaluation?</p> <p><input type="checkbox"/>Home</p> <p><input type="checkbox"/>Relative's home</p> <p><input type="checkbox"/>Non-relative's home</p> <p><input type="checkbox"/>Adult Care Home</p> <p><input type="checkbox"/>Family Care Home</p> <p><input type="checkbox"/>Nursing Home</p> <p><input type="checkbox"/>Multiunit Assisted Housing with Services (MUAHS)</p> <p><input type="checkbox"/>Other:</p>
<p>* Where was the Adult living at the beginning of the APS Evaluation?</p> <p><input type="checkbox"/>Home</p> <p><input type="checkbox"/>Relative's home</p> <p><input type="checkbox"/>Non-relative's home</p> <p><input type="checkbox"/>Adult Care Home</p> <p><input type="checkbox"/>Family Care Home</p> <p><input type="checkbox"/>Nursing Home</p> <p><input type="checkbox"/>Multiunit Assisted Housing with Services (MUAHS)</p> <p><input type="checkbox"/>Other:</p>	<p>* Did the Adult have a substitute decision maker at the conclusion of the APS Evaluation?</p> <p><input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No</p> <p>*If yes, Select the type of substitute decision maker at the conclusion of the APS Evaluation:</p> <p>*If other:</p>
<p>* Did the Adult have a substitute decision maker at the beginning of the APS Evaluation?</p> <p><input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No</p> <p>*If yes, Select the type of substitute decision maker at the beginning of the APS Evaluation:</p> <p>*If other:</p>	

Case Decision Section

<p>* Case decision:</p>	<p>* Type(s) of mistreatment confirmed (select all that apply). When a caregiver (including a guardian) is present, select caretaker neglect; when no caregiver is involved, select self-neglect. Both cannot be selected.</p> <p><input type="checkbox"/> Abuse – Causing Pain or Injury</p> <p><input type="checkbox"/> Abuse – Other:</p> <p><input type="checkbox"/> Caretaker Neglect</p> <p><input type="checkbox"/> Self Neglect</p> <p><input type="checkbox"/> Exploitation of the Person</p> <p><input type="checkbox"/> Exploitation of Assets</p> <p><input type="checkbox"/> No Mistreatment</p>
<p>* Date of case decision:</p>	
<p>* Need for protective services:</p> <p><input type="checkbox"/> Yes - must be checked if substantiated</p> <p><input type="checkbox"/> No - must be checked if unsubstantiated</p>	
<p>* DA/LE contacted:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>*If yes, date DA/LE contacted:</p>	

Authorization Section

Perpetrator is self (If this box is checked, the perpetrator section will be skipped):

☐ Yes

*** Contributing factors to disabled Adult's A/N/E (select all that apply):**

- ☐ Mental/Emotional Impairment
- ☐ Physical Impairment
- ☐ Dependent – Physically Frail
- ☐ Dependent – Emotionally/Financially
- ☐ Inadequate Income/Fiscal Management
- ☐ History of Family Violence
- ☐ Unsafe Environment
- ☐ Unstable Living Arrangement
- ☐ Inadequate Healthcare
- ☐ Social Isolation
- ☐ Lack of Support for Caregiver
- ☐ Inadequate Knowledge of Care Needs
- ☐ Traumatic Brain Injury (TBI)
- ☐ Intellectual Developmental Disability (IDD)
- ☐ Substance Use/Misuse
- ☐ None
- ☐ Other:

*** Type of authorization:**

*** Other Court Orders obtained (select all that apply):**

- ☐ Order to Review/Freeze Assets
- ☐ Order to Enjoin Caretaker
- ☐ Involuntary Commitment
- ☐ Subpoena Directing Release of Financial Records
- ☐ None
- ☐ Other:

Agency Assistance Section

You can only add one assisting agency type per record.

☐ No agency assistance was requested.

Assisting agency: If other:	Date assistance initially requested: Assistance received: <input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting agency: If other:	Date assistance initially requested: Assistance received: <input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting agency: If other:	Date assistance initially requested: Assistance received: <input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting agency: If other:	Date assistance initially requested: Assistance received: <input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting agency: If other:	Date assistance initially requested: Assistance received: <input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting agency: If other:	Date assistance initially requested: Assistance received: <input type="checkbox"/> Yes <input type="checkbox"/> No

Perpetrator Section

If you selected “perpetrator is self” skip this section. Duplicate for additional entries.

* First Name:	Middle Initial:
* Last Name:	Suffix:
DOB:	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Puerto Rican	Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unreported <input type="checkbox"/> White
Street Address:	City:
State:	Zip Code:
* Relationship to Adult: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-relative Caregiver <input type="checkbox"/> Facility staff/Nursing Combo Facility <input type="checkbox"/> Facility staff/Adult Care Home <input type="checkbox"/> Facility staff MH/DD/SA Home <input type="checkbox"/> Child <input type="checkbox"/> Non-relative, Non-caretaker	*Perpetrator Contributing Factors (select all that apply): <input type="checkbox"/> Mental/Emotional Impairment <input type="checkbox"/> Physical Impairment <input type="checkbox"/> Substance Abuse/Misuse <input type="checkbox"/> Dependent – Physically Frail <input type="checkbox"/> Dependent – Emotionally/Financially <input type="checkbox"/> Inadequate Income/Fiscal Management <input type="checkbox"/> History of Family Violence <input type="checkbox"/> Unsafe Environment <input type="checkbox"/> Unstable Living Arrangement <input type="checkbox"/> Inadequate Healthcare <input type="checkbox"/> Social Isolation <input type="checkbox"/> Lack of Support for Caregiver

<p>* Misuse of opioids by perpetrator:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not applicable</p>	<p><input type="checkbox"/> Traumatic Brain Injury (TBI)</p> <p><input type="checkbox"/> Intellectual Developmental Disability (IDD)</p> <p><input type="checkbox"/> Inadequate Supervision/Management</p> <p><input type="checkbox"/> Inadequate Knowledge/Training of Care Needs</p> <p><input type="checkbox"/> Inadequate Staffing</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Other:</p> <p><input type="checkbox"/> Other factors relating to facility staff:</p>
<p>*Perpetrator Disability (select all that apply):</p> <p><input type="checkbox"/> Alzheimer's Disease/Other Related Disorders</p> <p><input type="checkbox"/> Cerebral Palsy</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Autism</p> <p><input type="checkbox"/> Intellectual Developmental Disability (IDD)</p> <p><input type="checkbox"/> Mental Illness</p> <p><input type="checkbox"/> Physical Illness/Injury</p> <p><input type="checkbox"/> Substance Use</p> <p><input type="checkbox"/> Traumatic Brain Injury (TBI)</p> <p><input type="checkbox"/> Mental Impairment</p> <p><input type="checkbox"/> Ambulatory Difficulty</p> <p><input type="checkbox"/> Cognitive Difficulty</p> <p><input type="checkbox"/> Communication Difficulty</p> <p><input type="checkbox"/> Hearing Difficulty</p> <p><input type="checkbox"/> Independent living Difficulty</p> <p><input type="checkbox"/> Selfcare Difficulty</p> <p><input type="checkbox"/> Vision Difficulty</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other:</p>	

<p>* Living with Adult at beginning of the Evaluation:</p> <p><input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No</p>	<p>* Living with Adult at case decision time:</p> <p><input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No</p>
<p>* Legal authority over Adult at Evaluation beginning:</p> <p><input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No</p> <p>*If yes select type:</p> <p><input type="checkbox"/>Healthcare POA</p> <p><input type="checkbox"/>Durable Power of Attorney (POA)</p> <p><input type="checkbox"/>Representative Payee</p> <p><input type="checkbox"/>General Guardian</p> <p><input type="checkbox"/>Guardian of the Person</p> <p><input type="checkbox"/>Guardian of the Estate</p> <p><input type="checkbox"/>Limited General Guardian</p> <p><input type="checkbox"/>Limited Guardian of the Person</p> <p><input type="checkbox"/>Limited Guardian of the Estate</p>	<p>A/N/E occurred while resident of facility:</p> <p><input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No</p> <p>*If yes: Name of facility where ANE occurred:</p> <p>*Perpetrator still employed at current facility:</p> <p><input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No</p> <p><input type="checkbox"/>Unsure</p> <p>*If no: Perpetrator employed at different facility:</p> <p><input type="checkbox"/>Yes</p> <p><input type="checkbox"/>No</p> <p><input type="checkbox"/>Unsure</p> <p>*If yes: Name of facility:</p>

Essential Services Section

Duplicate for additional entries.

Essential Service: <input type="checkbox"/> Counseling <input type="checkbox"/> In-Home Aide Services <input type="checkbox"/> Day care/Day health <input type="checkbox"/> Transportation <input type="checkbox"/> Placement <input type="checkbox"/> Medical/Health care <input type="checkbox"/> Mental health <input type="checkbox"/> Institutional respite <input type="checkbox"/> Food/Clothing/Shelter <input type="checkbox"/> Financial assistance <input type="checkbox"/> Legal/surrogate decision maker <input type="checkbox"/> Money management <input type="checkbox"/> Other:	*Availability: <input type="checkbox"/> Needed and available <input type="checkbox"/> Needed but not available at time of case decision *Barrier to Providing Essential Service (if needed and not available): <input type="checkbox"/> Waiting list <input type="checkbox"/> Service doesn't exist <input type="checkbox"/> Other <input type="checkbox"/> How will the essential service be provided:
Essential Service: <input type="checkbox"/> Counseling <input type="checkbox"/> In-Home Aide Services <input type="checkbox"/> Day care/Day health <input type="checkbox"/> Transportation <input type="checkbox"/> Placement <input type="checkbox"/> Medical/Health care <input type="checkbox"/> Mental health <input type="checkbox"/> Institutional respite <input type="checkbox"/> Food/Clothing/Shelter <input type="checkbox"/> Financial assistance <input type="checkbox"/> Legal/surrogate decision maker <input type="checkbox"/> Money management <input type="checkbox"/> Other:	*Availability: <input type="checkbox"/> Needed and available <input type="checkbox"/> Needed but not available at time of case decision *Barrier to Providing Essential Service (if needed and not available): <input type="checkbox"/> Waiting list <input type="checkbox"/> Service doesn't exist <input type="checkbox"/> Other <input type="checkbox"/> How will the essential service be provided:

<p>Essential Service:</p> <p><input type="checkbox"/>Counseling</p> <p><input type="checkbox"/>In-Home Aide Services</p> <p><input type="checkbox"/>Day care/Day health</p> <p><input type="checkbox"/>Transportation</p> <p><input type="checkbox"/>Placement</p> <p><input type="checkbox"/>Medical/Health care</p> <p><input type="checkbox"/>Mental health</p> <p><input type="checkbox"/>Institutional respite</p> <p><input type="checkbox"/>Food/Clothing/Shelter</p> <p><input type="checkbox"/>Financial assistance</p> <p><input type="checkbox"/>Legal/surrogate decision maker</p> <p><input type="checkbox"/>Money management</p> <p><input type="checkbox"/>Other:</p>	<p>*Availability:</p> <p><input type="checkbox"/>Needed and available</p> <p><input type="checkbox"/>Needed but not available at time of case decision</p> <p>*Barrier to Providing Essential Service (if needed and not available):</p> <p><input type="checkbox"/>Waiting list</p> <p><input type="checkbox"/>Service doesn't exist</p> <p><input type="checkbox"/>Other</p> <p><input type="checkbox"/>How will the essential service be provided:</p>
<p>Essential Service:</p> <p><input type="checkbox"/>Counseling</p> <p><input type="checkbox"/>In-Home Aide Services</p> <p><input type="checkbox"/>Day care/Day health</p> <p><input type="checkbox"/>Transportation</p> <p><input type="checkbox"/>Placement</p> <p><input type="checkbox"/>Medical/Health care</p> <p><input type="checkbox"/>Mental health</p> <p><input type="checkbox"/>Institutional respite</p> <p><input type="checkbox"/>Food/Clothing/Shelter</p> <p><input type="checkbox"/>Financial assistance</p> <p><input type="checkbox"/>Legal/surrogate decision maker</p> <p><input type="checkbox"/>Money management</p> <p><input type="checkbox"/>Other:</p>	<p>*Availability:</p> <p><input type="checkbox"/>Needed and available</p> <p><input type="checkbox"/>Needed but not available at time of case decision</p> <p>*Barrier to Providing Essential Service (if needed and not available):</p> <p><input type="checkbox"/>Waiting list</p> <p><input type="checkbox"/>Service doesn't exist</p> <p><input type="checkbox"/>Other</p> <p><input type="checkbox"/>How will the essential service be provided:</p>

Journal Entry

If the DHHS-AS-5026 form is entered more than 15 calendar days after the case decision date in NC OAASIS, a justification for the late entry must be provided. This section may also be used to share information with DHHS Division of Social Services – Adult Services staff, a supervisor, or another agency staff member related to the record.