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

# **Division of Aging and Adult Services**

**Facility Evaluation**

**IDENTIFYING INFORMATION:**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name:** | **First Name:** | **Middle Initial:** | **Alias:** |
|  |  |  |  |
| **Date of Birth** | **Age** | **Gender** | **Race** |
|  |  | [ ] Male[ ] Female[ ] Other | [ ] African American[ ] Asian[ ] Caucasian[ ] Hispanic[ ] Native American [ ] Other |

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

**Family’s Primary Language**: [ ]  English [ ]  Spanish [ ]  Other

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

**Facility Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Telephone Number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Room Number:** \_\_\_\_\_\_\_\_\_

**Level of Care:** [ ] Nursing Home[ ] Domiciliary Care[ ] Group Home [ ] Other (Please Specify)

Driving Directions to Current Address or Location:

**Admission Date:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education Level:** **[ ]** High school graduate [ ]  College graduate [ ]  PhD

 [ ]  Post-secondary education [ ]  Masters [ ]  Other \_\_\_\_\_\_\_\_\_\_

**Able to Write:** [x] Yes[ ] No

**Able to Read:** [ ] Yes[ ] No

**Religious Preference:** [ ] Baptist [ ] Catholic [ ] Protestant [ ] Non-denomination

[ ] Non-affiliated [ ] Other

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

**History of Reports:** [ ]  Yes [ ]  No If yes, provide dates of previous APS reports: (Within last two years)

|  |
| --- |
| Dates of reports listed below |
|  |
|  |
|  |

**Were photos taken of adult Included in file:** [ ]  Yes [ ]  No If yes, Where?

**Same Perpetrator :**  [ ]  Yes [ ]  No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Date** | **Time** | **AM** | **PM** |  |
| **Date of the current report** |  |  | [ ]  | [ ]  |  |
| **Report initiated** |  |  | [ ]  | [ ]  |  |
| Contact with Facility Administrator |  |  | [ ]  | [ ]  |  |
| Date of first face to face contact with adult |  |  | [ ]  | [ ]  |  |
| Date of first private interview with adult  |  |  | [ ]  | [ ]  |  |
| Date of Initial notice to reporter |  |  | [ ]  | [ ]  | Written [ ] Verbal [ ]   |
| Date of final notice to reporter |  |  | [ ]  | [ ]  | Written [ ] Verbal [ ]  |
| Date of case decision |  |  | [ ]  | [ ]  |  |
| Dates of required notice (as needed) |  |  | [ ]  | [ ]  | DA |
| Date of required notice (as needed) |  |  | [ ]  | [ ]  | LE |
| Date of notice (if appropriate) |  |  | [ ]  | [ ]  | AHS/DHSR |
| Date of notice (other) |  |  | [ ]  | [ ]  |  |
| 5027 completed for 202 services |  |  | [ ]  | [ ]  |  |

**Types of Maltreatment Alleged (in the report):**

[ ]  Abuse causing pain/injury [ ]  Abuse [ ]  Caretaker Neglect [ ]  Self-Neglect [ ]  Exploitation of Assets

[ ]  Exploitation of Person

[ ]  **At substantial risk**. If Yes [ ]  (specify type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No

**Summary of Allegations:**

Were there any problems accessing the adult? [ ]  Yes or [ ]  No

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

|  |  |
| --- | --- |
| Dates | Efforts to resolve explained below |
|  |  |
|  |  |
|  |  |
|  |  |

Did a life-threatening situation exist? ☐ Yes or ☐ No

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

**SOCIAL SUPPORT**

Family and Significant Others Outside Facility

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Type, Frequency of Contact** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Describe the relationship between the adult and facility staff:

Describe the relationship between the adult and the other residents of the facility:

Are there any community agencies involved with the adult? [ ] Yes or [ ] No

If yes, list:

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency Name** | **Contact Person** | **Telephone Number** | **Purpose & Frequency of Contact** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

 **Environment: Environment Risk Factors**

Select Yes or No:

|  |  |  |
| --- | --- | --- |
| [ ] Yes | [ ] No | Sleeping Accommodations  |
| [ ] Yes | [ ] No | Deteriorating Structure |
| [ ] Yes | [ ] No | Eating Area  |
| [ ] Yes | [ ] No | Heating/Cooling  |
| [ ] Yes | [ ] No | Fire Hazards/ no smoke detectors  |
| [ ] Yes | [ ] No | Laundry  |
| [ ] Yes | [ ] No | Unsanitary Conditions (specify)  |
| [ ] Yes | [ ] No | Lighting |
| [ ] Yes | [ ] No | Pest/Vermin |
| [ ] Yes | [ ] No | Toilet Facilities |
| [ ] Yes | [ ] No | Water/ Plumbing |
| [ ] Yes | [ ] No | Lack of access to/from general areas in facility |
| [ ] Yes | [ ] No | Lack of access to/from general exterior of facility |
| [ ] Yes | [ ] No | External risk hazards |
| [ ] Yes | [ ] No | Internal risk hazards |
| [ ] Yes | [ ] No | Others (Specify) |
| Comments |  |

**Level of Endangerment:**

[ ]  Immediate Life Threat [ ]  Potential of Serious Harm [ ]  No Evident Danger

[ ]  At Substantial Risk

**Description of Conditions and Risk Factors:**

**If there are environmental conditions that place the adult and other resident/patients of the facility at risk, identify the date and method of reporting the conditions to the Adult Home Specialist or Health Services Regulation**

**The following are indicators of mistreatment in facility settings. Presence of these “red flags” indicate a possible risk for maltreatment and requires careful evaluation. “Yes” to any of these indicators requires that information is needed to determine the effect it has on the adult’s safety.**

**\*Source Code**

**C**=Client Statement **M**=FL-2, other medical

**F**= Family member/guardian/responsible party **S**=Social worker

**O**=Other collateral

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Resident Risk Factors** | **Yes** | **No** | \***Source** | **Comments** |
| Alcohol/Drug Abuse |[ ] [ ]   |  |
| Self-blaming |[ ] [ ]   |  |
| Assaultive/hostile |[ ] [ ]   |  |
| History of multiple incidents |[ ] [ ]   |  |
| Fearful of caregivers |[ ] [ ]   |  |
| Stoicism (No Emotions) |[ ] [ ]   |  |
| Sexual acting out behavior(s) |[ ] [ ]   |  |
| Self-abusive behavior(s) |[ ] [ ]   |  |
| Demanding |[ ] [ ]   |  |
| Passive/passive aggressive |[ ] [ ]   |  |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Facility Risk Factors** | **Yes** | **No** | **\*Source** | **Comments** |
| Accepting residents whose needs cannot be met by facility |[ ] [ ]   |  |
| Crowding/concentration of vulnerable adults |[ ] [ ]   |  |
| High personnel turnover |[ ] [ ]   |  |
| Frequent “reorganizations” |[ ] [ ]   |  |
| High overtime demands |[ ] [ ]   |  |
| Inadequate and uninformed administrator/manager response to Abuse/Neglect/Exploitation |[ ] [ ]   |  |
| Inconsistent and unclear job expectations of staff |[ ] [ ]   |  |
| Lack of staff training which means that staff are not prepared to act wisely |[ ] [ ]   |  |
| Staff shortages (e.g., facility not meeting minimum staffing requirements per State regulations, least experienced staff required to work holiday when staffing is skeletal, etc.) |[ ] [ ]   |  |
| Poor communication between administrators andStaff (In both directions) |[ ] [ ]   |  |
| Previous APS Reports |[ ] [ ]   |  |
| Poor building maintenance (ventilation, lighting, etc.) |[ ] [ ]   |  |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Alleged Perpetrator Risk Factors** | **Yes** | **No** | **\*Source** | **Comments** |
| Alcohol/drug abuse |[ ] [ ]   |  |
| Lack of training in job responsibilities |[ ] [ ]   |  |
| Excessive absenteeism |[ ] [ ]   |  |
| Blaming adult / hypercritical |[ ] [ ]   |  |
| Private gifts to the adult |[ ] [ ]   |  |
| Reluctance to provide care |[ ] [ ]   |  |
| Favoritism toward the adult |[ ] [ ]   |  |
| Numerous disciplinary actions |[ ] [ ]   |  |
| Overeager to provide care |[ ] [ ]   |  |
| Role reversal (i.e., looking to resident to fulfill their needs |[ ] [ ]   |  |
| Tardiness/unexplained absences |[ ] [ ]   |  |
| Social isolation |[ ] [ ]   |  |
| Works excessive hours |[ ] [ ]   |  |

**ECONOMIC FUNCTIONING**

Adult's financial affairs are managed by: [ ]  Self [ ]  Other- Name and relationship:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Income** | **Monthly Amount** | **Expenses** | **Monthly Amount** | **Benefits Received** | **Monthly Amount** |
| Social Security |  | Room & Board |  | Medicare Part A |  |
| SSI |  | Resident Trust Account |  | Medicare Part B |  |
| VA Pension |  | Medicine |  | Medicaid |  |
| RR Retirement |  | Life Insurance |  | Special Assistance (SA) |  |
| Other Pension |  | Health Insurance |  | Other Health Insurance |  |
| Public Assistance |  | Burial |  | FNS Benefits  |  |
| Interest/dividends |  | Other Medical Expenses |  | Other (specify) |  |
| Other (specify) |  |  |  |  |  |

|  |  |
| --- | --- |
| Medicare Number |  |
| Medicaid Number |  |
| Health Insurance (Company and Policy #) |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Assets:** Provide value, description and location of assets, if known |
| Checking account |  |
| Savings account |  |
| Real estate |  |
| Securities |  |
| Personal |  |
| Burial |  |
| Other (Specify) |  |

Legal Status: Does the adult have one or persons who represent them as:

**Date authority given**

|  |  |
| --- | --- |
|  [ ]  Legal Guardian |  |
|  [ ]  Guardian of Person |  |
|  [ ]  Guardian of Estate |  |
|  [ ]  General |  |

Identify any limitation placed on the Guardianship:

|  |  |
| --- | --- |
| Power of Attorney (Identify type) | Registered in: [ ]  County \_\_\_\_\_\_\_\_\_\_ [ ]  State \_\_\_\_\_\_\_\_ |
|  [ ]  General | **Date given:** |
|  [ ]  Durable | **Date given:** |
|  [ ]  Health care | **Date given:** |
|  [ ]  Living Will  | **Date given:** |

Representative payee for

If adult has legal and /or payee representative, list contact information below:

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Telephone number** |  |
| **Type** |  |

Contact made with the adult’s legal representative [ ]  Yes [ ]  No

What is the adult’s legal representative’s response to the allegations of mistreatment of the adult (e.g. does the representative have any concerns related to the reported allegations? What does the representative plan to do/not do, in response to the allegations of mistreatment?).

**Mental/Emotional Functioning:**

**A. Orientation**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Time: | Does the adult know the correct day of the week? | [ ] Yes | [ ] No | [ ] Non-Responsive | [ ] Refused to Answer |
|  | Does the adult know the correct month? | [ ] Yes | [ ] No | [ ] Non-Responsive | [ ] Refused to Answer |
|  | Does the adult know the correct year? | [ ] Yes | [ ] No | [ ] Non-Responsive | [ ] Refused to Answer |
| Place: | Does the adult know the name of the facility where he/she is residing? | [ ] Yes | [ ] No | [ ] Non-Responsive | [ ] Refused to Answer |
| Self: | Does the adult know his/her name? | [ ] Yes | [ ] No | [ ] Non-Responsive | [ ] Refused to Answer |
|  | Does the adult his/her relationship to significant others? | [ ] Yes | [ ] No | [ ] Non-Responsive | [ ] Refused to Answer |

**B. Memory**

Assess distant, recent, and immediate memory. Responses to many of the other questions asked during the interview can be used to complete the ratings. 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** |

|  |  |
| --- | --- |
|  | **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:**

**C. Judgment**

Assess the client’s response to both routine and emergency situations. Enter one of the responses below on the line in front of each area.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **1-Good decision making/problem solving skills** | **2-Mild deficit: can handle everyday decisions/problems, but not good with complex issues** | **3-Moderate deficit: questionable decision making/problem solving skills; may be able to handle some****routine decisions** |  **4-Severe deficit: difficulty with 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; need assistance from staff; concern about food; staff treatment); and assess ability to gather and accept facts, weigh advice, make decisions, and understand their consequences. |
|  | EMERGENCY: Describe several emergency situations that may occur (e.g., power goes out, adult falls, roommate falls; sees or smells smoke), and assess ability to gather and accept facts, weigh advice, discern unsafe/threatening situations |

**COMMENTS:**

**D. Arithmetic**

The adult’s ability to handle simple arithmetic tasks provides an indication of mental function, distinguishes between depression and dementia, and is linked to the capability 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 adult to perform simple tasks such as subtracting by “2’s” from 20. Enter one of the response below to indicate the adult’s arithmetic ability.

|  |  |  |  |
| --- | --- | --- | --- |
| **1-Adult can perform simple tasks with no or minimal errors** | **2-Adult cannot perform simple tasks with reliable accuracy** | **3 Adult non-responsive** | **4-Refused to answer** |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Arithmetic Ability**

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**E. MENTAL/EMOTIONAL ASESSMENT**

|  |  |  |
| --- | --- | --- |
| **Diagnosis/Symptom** | **\*Source** | **Notes (e.g., onset, severity, functional impact, history, untreated condition, needs professional assessment, current treatment)** |
| Aggressive/abusive behavior |  |  |
| Agitation/Anxiety/Panic attacks |  |  |
| Change in activity level(sudden extreme) |  |  |
| Change in appetite |  |  |
| Cognitive impairment/memoryImpairment (specify) |  |  |
| Intellectual and Developmental disability(Specify) |  |  |
| Hallucinations/Delusions |  |  |
| Inappropriate affect (flat or incongruent) |  |  |
| Impaired judgment |  |  |
| Mental anguish |  |  |
| Mental illness (Specify) |  |  |
| Orientation impaired:Person, self, place, time |  |  |
| Persistent sadness |  |  |
| Sleep disturbances |  |  |
| Substance use disorder(Specify) |  |  |
| Thoughts of death/suicide |  |  |
| Wandering |  |  |
| Other: |  |  |

**MENTAL HEALTH**

Does the adult have a Mental Health Diagnosis or Condition? [ ] Yes [ ] No If Yes, list diagnosis or condition

|  |  |
| --- | --- |
| 1. | 3. |
| 2. | 4. |

**ACTIVITIES/ INSTRUMENTAL ACTIVITIES OF DAILY LIVING**

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ADL & IADL Tasks** | **Indepen-dent** | **Some****Assist** | **Totally****Dependent** | **\*Source** | **Needs Met?** | **Comments** |
| Ambulation | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Bathing | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Dressing | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Eating | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Grooming | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Toileting | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
|  Transfer |  |  |  |  |  |  |
| To/from bed | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| To/from chair | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Into/out of car | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Shopping | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Using Transportation | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Money Management | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |
| Telephone Use | **[ ]**  | **[ ]**  | **[ ]**  |  | [ ] Yes [ ] No |  |

**PHYSICAL HEALTH**

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|  |  |  |
| --- | --- | --- |
| **Diagnosis/Symptom** | **\*Source** | **Notes (e.g. onset, severity, history, functional impact, untreated condition, needs professional assessment, current treatment)** |
| Arthritis / osteoporosis / gout |  |  |
| Asthma / emphysema / COPD/other respiratory |  |  |
| Bladder / urinary problems or incontinence |  |  |
| Bowel problems or incontinence |  |  |
| Cancer |  |  |
| Dental problems |  |  |
| Diabetes |  |  |
| Dizziness / falls |  |  |
| Eye disease or conditions |  |  |
| Headaches |  |  |
| Hearing difficulty |  |  |
| Heart disease / angina |  |  |
| Hypertension / high blood pressure |  |  |
| Kidney disease / renal failure |  |  |
| Liver diseases |  |  |
| M. Sclerosis / M. Dystrophy / C. Palsy |  |  |
| Pain |  |  |
| Paraplegia / quadriplegia / spinal problems |  |  |
| Parkinson’s disease |  |  |
| Rapid weight gain / loss |  |  |
| Seizures |  |  |
| Shortness of breath / persistent cough |  |  |
| Skin Condition/wounds/sores/rash(Specify) |  |  |
| Speech impairment |  |  |
| Stroke |  |  |
| Other: |  |  |

**Date adult was last seen by a physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

APS worker contact with adult’s physician? [ ]  Yes [ ]  No [ ] Unnecessary

If Yes, please provide the following information:

|  |  |
| --- | --- |
| Provider’s name |  |
| Provider’s primary contact number |  |
| Name of facility/office |  |

**Findings:**

**\*\*\*\*\*MEDICAL REPORTS REVIEWED (Check, date, attach all that apply) \*\***

**\*\*\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Check if documents(s) attached** | **Document** | **Date Reviewed** | **Comments** |
|  Resident/Patient Incident Reports | ☐Yes ☐No |  |  |
|  Physician Notes | ☐Yes ☐No |  |  |
|  Physician Orders | ☐Yes ☐No |  |  |
|  Nursing Assessments | ☐Yes ☐No |  |  |
|  Nurses Notes | ☐Yes ☐No |  |  |
|  Social Work Assessment & Progress Notes | ☐Yes ☐No |  |  |
|  Plan of Care | ☐Yes ☐No |  |  |
|  Medication Administration Records | ☐Yes ☐No |  |  |
|  Pertinent Staff Training Information | ☐Yes ☐No |  |  |
|  Staff Work Schedules | ☐Yes ☐No |  |  |
|  Other (specify): | ☐Yes ☐No |  |  |

Has Adult recently been hospitalized? [ ] Yes [ ] No If yes, give date and location:

If yes, give reason

**MEDICATIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **OTC** | **Prescription** | **Date filled** | **Note dosage, frequency or possible side effects** |
|  | [ ]  | [ ]  |  |  |
|  | [ ]  | [ ]  |  |  |
|  | [ ]  | [ ]  |  |  |
|  | [ ]  | [ ]  |  |  |

Copy of MAR Attached? [ ] Yes [ ]  No

Name of Pharmacy used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the adult receiving medication as prescribed? ☐Yes ☐ No

If no, why not?

**COLLATERAL CONTACT INFORMATION**

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

**EVIDENCE OF ABUSE, NEGLECT OR EXPLOITATION OR AT 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).

**ABUSE BY CARETAKER - check all that apply**

|  |  |  |
| --- | --- | --- |
| [ ]  Hitting, slapping, or kicking | [ ]  Old and/or New bruises, welts, bruises, or injuries | [ ]  Injuries to head, face, genitals |
| [ ]  Restrained, tied, locked in, isolated | [ ]  Non-consenting sexual activity | [ ]  Objects thrown at adult |
| [ ]  Verbal assaults, threats | [ ]  Threatened/injured with a weapon | [ ]  Prolonged interval between injury and treatment |
| [ ]  Injuries in odd places | [ ]  Demonstrates fear of caretakers | [ ]  Explanation inconsistent with injury |
| [ ]  Adult fearful of others | [ ]  Willful Deprivation | [ ]  Non-Applicable |
| [ ]  Other (specify):  |  |  |

**Level of Endangerment**

|  |  |  |
| --- | --- | --- |
| [ ]  Immediate life threat | [ ]  Adult understands | [ ]  Adult willing to accept assistance |
| [ ]  Potential of serious harm | [ ]  Adult does not understand | [ ]  Adult unwilling to accept assistance |
| [ ]  At substantial risk | ☐ No evident danger | [ ]  Not Applicable |

Comments/Description (if needed):

**Neglect: (Check all that apply)**

|  |  |  |
| --- | --- | --- |
| [ ]  Excess dirt, fleas, lice on person | [ ]  Malnourished or dehydrated | [ ]  Fecal/urine smell or presence |
| [ ]  Bedsores or other ulcerated sores | [ ]  Doesn’t get/take medications | [ ]  Inadequate clothing |
| [ ]  Dental problems | [ ]  Skin rashes, discoloration | [ ]  Overgrown nails |
| [ ]  Lack of glasses/hearing aid or other prostatic devices | [ ]  Untreated medical needs (specify): | [ ]  Lack of needed supervision |
| [ ]  Lack of needed assistance with ADLs | [ ]  Prolonged time between illness/injuries and medical care | [ ]  Other: (specify) |
|  |  | [ ]  Not applicable |

**Level of Endangerment**

|  |  |  |
| --- | --- | --- |
| [ ]  Immediate life threat | [ ]  Adult understands | [ ]  Adult willing to accept assistance |
| [ ]  Potential of serious harm | [ ]  Adult does not understand | [ ]  Adult unwilling to accept assistance |
| [ ]  At substantial risk | ☐ No evident danger | [ ]  Not Applicable |

Comments/Description (if needed):

**Self-Endangering Behaviors: (Check all that apply)**

|  |  |  |
| --- | --- | --- |
| [ ]  Suicidal threats | [ ]  Refuses medical treatment | [ ]  Wandering |
| [ ]  Suicidal acts | [ ]  Denial of problems | [ ]  Frequent dangerous places (specify): |
| [ ]  Refused medication | [ ]  Abuse of medications [ ]  RX [ ]  OTC | [ ]  Refuses mental health Tx |
| [ ]  Self-inflicted injuries | [ ]  Other (Specify) | [ ]  Not applicable |
| [ ]  Substance use disorder (Specify) |  |  |

**Level of Endangerment: (Check all that apply)**

|  |  |  |
| --- | --- | --- |
| [ ]  Immediate life threat | [ ]  Adult understands | [ ]  Adult willing to accept assistance |
| [ ]  Potential of serious harm | [ ]  Adult does not understand | [ ]  Adult unwilling to accept assistance |
| [ ]  At substantial risk | ☐ No evident danger | [ ]  Not Applicable |

**D. EXPLOITATION OF ASSETS**

|  |  |  |
| --- | --- | --- |
| [ ]  Unexplained disappearance of funds of valuables | [ ]  Caretaker refuses to use adult's funds to meet daily care needs | [ ]  Chronic failure to pay for services and/or bills |
| [ ]  Depleted funds/banks account, Questionable reason | [ ]  Checks un-cashed | [ ]  Transfer of other assets without adult's knowledge & benefit |
| [ ]  Adult unaware of income amount & expenses | [ ]  Unusual activity in bank account | [ ]  Facility misusing adult's money |
| [ ]  Family misusing adult's money | [ ]  Significant Debt | [ ]  Other (specify): |
| [ ]  Lack of payment arrangements to facility & responsible | [ ]  Money lost or misplace |  |
| [ ]  Evasive about making arrangements | [ ]  Not Applicable |  |

**Level of Endangerment**

|  |  |  |
| --- | --- | --- |
| [ ]  Immediate life threat | [ ]  Adult understands | [ ]  Adult willing to accept assistance |
| [ ]  Potential of serious harm | [ ]  Adult does not understand | [ ]  Adult unwilling to accept assistance |
| [ ]  At substantial risk | [ ]  Not Applicable |  |
| [ ]  No evident danger |  |  |

**Comments/Description (if needed):**

**E. EXPLOITATION OF THE PERSON**

|  |  |  |
| --- | --- | --- |
| [ ] Sexual exploitation | [ ] Coerced to perform tasks | [ ]  Forced to work without pay or fair compensation |
| ☐Other (specify): | ☐Not Applicable |  |

**Level of Endangerment**

|  |  |  |
| --- | --- | --- |
| [ ]  Immediate life threat | [ ]  Adult understands | [ ]  Adult willing to accept assistance |
| [ ]  Potential of serious harm | [ ]  Adult does not understand | [ ]  Adult unwilling to accept assistance |
| [ ]  At substantial risk | ☐ No evident danger | [ ]  Not Applicable |

Comments/Description (if needed):

**Summary of adults understanding and willingness to accept assistance:**

Adult previously victimized? [ ]  No [ ]  One time [ ] Several times over a short period of time

[ ]  Many times, over a long period of time [ ]  Unknown [ ]  Other, Explain:

**Alleged Perpetrator Information**

|  |  |
| --- | --- |
| Current alleged perpetrator's name |  |
| Date of Birth |  |
| Telephone Number |  |
| Relationship |  |
| Date of Contact |  |

Alleged perpetrator's contact with client: [ ] Daily [ ] Weekly [ ] Other: Please Explain

Alleged perpetrator's Employment: Shift Worked:\_\_\_\_\_\_\_\_\_ Days Worked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alleged perpetrator's reaction to APS Worker: [ ]  Cooperative [ ]  Uncooperative [ ]  Refused to be interviewed[ ]  Interviewed with legal counsel

Summary of alleged perpetrator's statement concerning APS allegations:

Criminal records checked: (optional):

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 lack of a thorough evaluation, lack of

 staffing resources, lack of formal resources, lack of access to the court system, or prior history with 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?

 b. Is the person emotionally mature, trustworthy, reliable, and have a history of using good judgment and sound thinking?

 c. Does this identified person understand the protective services needs and willing to make sure that all of the needs are met?

 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?

**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 wellbeing.

Has a caretaker? [ ] Yes [ ] No

**ABUSE:**

The willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or the 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 himself services which are necessary to maintain his physical or mental health or is not receiving the services from his/her caretaker**.**

Has been Neglected by their Caretaker? [ ]  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? | [ ]  Yes [ ]  No |
| Need for APS has been unsubstantiated? | [ ]  Yes [ ]  No |
| Maltreatment confirmed but unsubstantiated | [ ]  Yes [ ]  No |

**If the Need for APS is substantiated, then complete Form # 0010: Determination of Ability to Consent**

**to Protective Services**

**SUBSTANTIAL RISK OF ABUSE, NEGLECT, OR EXPLOITATION:**

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.

|  |  |  |
| --- | --- | --- |
| Is at Substantial Risk? | ☐ Yes ☐ No |  |
| Services Offered? | ☐ Yes ☐ No | [ ]  Refused [ ]  Accepted  |
| Client Referred to: |  |

|  |  |
| --- | --- |
|  |  |
| **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.**