Family Care/IRIS Referral for APS Services:

EA (Elder Abuse), AAR (Adults-at-Risk), Guardianship (Ch. 54), Protective Services (Ch.55), & Mental Health (Ch. 51) for GSRs: 1, 3, 5, & 5/6.

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| **Date:** |  |

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| **Member Information** | | | | | | | | | | |
| **Member Name:** |  | | | | | F  M | | | DOB: |  |
| **Street Address:** |  | | **City:** | |  | | **State, Zip:** | | |  |
| **Marital Status:** | Single  Married  Divorced  Widowed | | | | | | | | | |
| **County of Residence:** | |  | | **County of Responsibility:** | | | |  | | |

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| **Purpose of Referral** | |
| Adult at Risk (age 18-59)  Elder Abuse (age 60 and over) | |
| Describe the situation related to abuse, neglect, self-neglect, or financial exploitation: | |
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| Guardianship  Protective Services/Placement  Other (specify): |  |

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| **Referral Information** | | | | | | | | | | | |
|  | | | | | | Address: |  | | | | |
| Power of Attorney (POA)  Activated:  Yes  No | | | | | | Name: |  | | | Phone #: |  |
| Address: |  | | | | |
| Representative Payee | | | | | | Name: |  | | | Phone #: |  |
| Address: |  | | | | |
| Primary Physician Name: | | | |  | | | | | | Phone #: |  |
| Clinic Address: | |  | | | | | | | | | |
| Primary Diagnosis: | | |  | | | | | | | | |
| Name: | | | | |  | | | | | Phone #: |  |
| Office City: |  | | | | | | | Email: |  | | |

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| **Contact Information** *(Complete if only for guardianship)* | | | | | | | |
| Name: |  | | | | | | |
| Address: |  | | City: |  | | State, Zip: |  |
| Phone #: |  | Spouse  Other (specify): | | |  | | |
| Name: |  | | | | | | |
| Address: |  | | City: |  | | State, Zip: |  |
| Phone #: |  | Spouse  Other (specify): | | |  | | |
| Name: |  | | | | | | |
| Address: |  | | City: |  | | State, Zip: |  |
| Phone #: |  | Spouse  Other (specify): | | |  | | |