

DEPARTMENT OF HEALTH SERVICES

Division of Long Term Care
F-20441A (01/2009)

STATE OF WISCONSIN

This tool is intended to assist users in collecting information to meet the requirements of s. 46.90(8)c Wisconsin Statutes

ADULT-AT-RISK ABUSE, NEGLECT, AND / OR EXPLOITATION DATA COLLECTION

SECTION A: INITIAL INFORMATION

Referral Date (mm/dd/yyyy)	Reporting Year	Previous Report? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	County/Tribe
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Text: Caller's Initial Concerns (see Valid Values list)

Category: Primary Issue Identified During Response (select ONE reason from Valid Values list)

If "Other," specify:

Details: Primary Issue Identified During Response	Other Issues Identified During Response

Date of Initial Contact (mm/dd/yyyy)	Was incident life-threatening?	Yes	No	Unknown
Incident Occurred At or Near: <input type="checkbox"/> Place of Residence <input type="checkbox"/> Other (specify)	If life-threatening, has individual died?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, was death related to incident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, was death directly caused by incident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Referral Source (see Valid Values list)	If "Other," specify:
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Call Received by (see Valid Values list)	If "Other," specify:
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Initial Response Agency Assigned (see Valid Values list)	If "Other," specify:
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SECTION B: INFORMATION ABOUT ADULT-AT-RISK

First Name (Elder Person)	MI	Last Name	Telephone Number
Address 1		Address 2	
City		State	Zip Code

Age in Years: _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Hmong <input type="checkbox"/> Neither	Race (see Valid Values list)
Is this: <input type="checkbox"/> Actual age <input type="checkbox"/> Estimated age	Living Arrangement (see Valid Values list)		

County or State Programs/Services <input type="checkbox"/> Community Support Program <input type="checkbox"/> Comprehensive Community Services <input type="checkbox"/> Family Care <input type="checkbox"/> Home & Community-Based Waivers <input type="checkbox"/> Medicaid (Title 19, Card Services) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> None	Is There a Substitute Decision-Maker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Type(s) of Substitute Decision-Maker (see Valid Values list): _____ _____ _____
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Adult-at-Risk Characteristics (see Valid Values list)		

If "Other," specify:

Reference Code (Optional)

SECTION C: INFORMATION ABOUT ALLEGED ABUSERS

FIRST ALLEGED ABUSER

First Name (Alleged Abuser)	MI	Last Name	Telephone Number
Address 1		Address 2	
City		State	Zip Code

FIRST ALLEGED ABUSER, CONTINUED

Age in Years Is this: <input type="checkbox"/> Actual age <input type="checkbox"/> Estimated age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Hmong <input type="checkbox"/> Neither	Race (see Valid Values list)
Relationship to Adult-at-Risk (see Valid Values list)		If "Other" relationship, specify:	Is Alleged Abuser a Caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Does Alleged Abuser live with Adult-at-Risk? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Alleged Abuser's Legal Status (check all that apply): <input type="checkbox"/> Conservator <input type="checkbox"/> POA-Finances – Not Activated <input type="checkbox"/> Temporary Guardian <input type="checkbox"/> Guardian of the Estate <input type="checkbox"/> POA-Health Care – Activated <input type="checkbox"/> None <input type="checkbox"/> Guardian of the Person <input type="checkbox"/> POA-Health Care – Not Activated <input type="checkbox"/> Unknown <input type="checkbox"/> POA-Finances – Activated <input type="checkbox"/> Representative Payee <input type="checkbox"/> Other (specify):		
Alleged Abuser Characteristics (see Valid Values list)			

If "Other," specify:

SECOND ALLEGED ABUSER

First Name (Alleged Abuser)	MI	Last Name	Telephone Number
Address 1		Address 2	
City		State	Zip Code
Age in Years Is this: <input type="checkbox"/> Actual age <input type="checkbox"/> Estimated age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Hmong <input type="checkbox"/> Neither	Race (see Valid Values list)
Relationship to Adult-at-Risk (see Valid Values list)		If "Other" relationship, specify:	Is Alleged Abuser a Caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Does Alleged Abuser live with Adult-at-Risk? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Alleged Abuser's Legal Status (check all that apply): <input type="checkbox"/> Conservator <input type="checkbox"/> POA-Finances – Not Activated <input type="checkbox"/> Temporary Guardian <input type="checkbox"/> Guardian of the Estate <input type="checkbox"/> POA-Health Care – Activated <input type="checkbox"/> None <input type="checkbox"/> Guardian of the Person <input type="checkbox"/> POA-Health Care – Not Activated <input type="checkbox"/> Unknown <input type="checkbox"/> POA-Finances – Activated <input type="checkbox"/> Representative Payee <input type="checkbox"/> Other (specify):		
Alleged Abuser Characteristics (see Valid Values list)			

If "Other," specify:

SECTION D: REPORT SUMMARY

Incident Result <input type="checkbox"/> Substantiated <input type="checkbox"/> Unsubstantiated <input type="checkbox"/> Unable to Substantiate	Action(s) Taken (see Valid Values list)
Services Planned for Adult-at-Risk (see Valid Values list)	
If "Other," specify:	
Services Planned for Alleged Abuser/s (see Valid Values list)	
If "Other," specify:	
Report Prepared by	Date Entry by (if different from Report Preparer)
Date Report Completed (mm/dd/yyyy)	

NOTE: This tool is for local use only. Do not send it to the Department of Health Services (DHS). Its purpose is to assist users in gathering information that will be reported to DHS using the web-based Elder Abuse Reporting System. Although this tool provides space to record personally identifiable information about elder abuse and alleged abusers, this identifying information is for local/county use only and will not be entered into the Elder Abuse Reporting System.