MANDATORY ABUSE REPORT

pennsylvania DEPARTMENT OF AGING

pennsylvania DEPARTMENT OF HUMAN SERVICES

DATE OF REPORT:	TIME:

NAME OF VICTIM / RECIPIENT/ CONSUMER (Last, First, M.I.):	FACILITY NAME:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP CODE :	CITY: STATE: ZIP CODE:
PHONE:	PHONE: COUNTY:
DATE OF BIRTH: SEX:	FACILITY TYPE: (NH, PCH, DC, CLA, etc.)
DATE AND TIME OF INCIDENT: DATE: / / TIME: _____:_____ A.M. P.M.	FACILITY LICENSING AGENCY: FACILITY LICENSE NUMBER:
DATE AND TIME OF REPORT TO LICENSING AGENCY: DATE: / / TIME: _____:_____ A.M. P.M.	LICENSING AGENCY CONTACT AND TELEPHONE NUMBER: NAME: TELEPHONE #::

OAPSA (over 60)

ABUSE TYPE: (Check one)

- ☐ ABUSE not Involving sexual abuse, serious bodily injury, serious physical injury or suspicious death
- ☐ SEXUAL ABUSE (rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest)
- ☐ SERIOUS BODILY INJURY ☐ SERIOUS PHYSICAL INJURY
- ☐ SUSPICIOUS DEATH

APS (under 60)

ABUSE/NEGLECT TYPE: (Check one)

- ☐ ABUSE, NEGLECT, EXPLOITATION or ABANDONMENT not Involving sexual abuse, serious injury, serious bodily Injury or suspicious death
- ☐ SEXUAL ABUSE (rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, or incest)
- ☐ SERIOUS INJURY
- ☐ SERIOUS BODILY INJURY ☐ SUSPICIOUS DEATH

DATE/TIME ORAL REPORT TO AAA:	NAME OF AAA CONTACTED:	*AAA/APS AGENCY USE ONLY:* DATE/TIME ORAL REPORT TO COUNTY CORONER: (if applicable)	*AAA/APS AGENCY USE ONLY:* NAME OF CORONER: (if applicable)

DATE/TIME ORAL REPORT TO LOCAL LAW ENFORCEMENT: (if applicable)	NAME OF LAW ENFORCEMENT AGENCY: (if applicable)	DATE/TIME ORAL REPORT TO PDA/DHS: (if applicable)

CONTACT INFORMATION: (PLEASE CHECK APPROPRIATE BLOCK) ☐ GUARDIAN ☐ ATTORNEY-IN-FACT ☐ NEXT OF KIN		ALLEGED PERPETRATOR NAME:	RELATIONSHIP TO VICTIM:
NAME:		ADDRESS:	
ADDRESS:		CITY: STATE: ZIP CODE:	
CITY: STATE : ZIP CODE:		PHONE NUMBER:	AGE: / SEX:
PHONE NUMBER:	RELATIONSHIP:	TYPE OF POSITION: (RN, LPN, CNA, etc.)	WORK SHIFT: / DATE OF HIRE:

PLEASE COMPLETE REVERSE SIDE

DETAILS AND DESCRIPTION OF ABUSE: (ATTACH ADDITIONAL SHEETS IF NECESSARY)

ACTIONS TAKEN BY FACILITY, INCLUDING TAKING OF PHOTOGRAPHS AND X-RAYS, REMOVAL OF VICTIM AND NOTIFICATION OF APPROPRIATE AUTHORITIES. (ATTACH ADDITIONAL SHEETS IF NECESSARY)

OTHER PERTINENT INFORMATION, COMMENTS OR OBSERVATIONS DIRECTLY RELATED TO ALLEGED ABUSE INCIDENT AND VICTIM:

NAME AND TITLE OF REPORTER: (PLEASE TYPE OR PRINT) **NAME:** **TITLE:**	**SIGNATURE OF REPORTER:**
REPORTER CONTACT INFORMATION: **TELEPHONE NUMBER:** **EMAIL ADDRESS:**	**DATE:**
NAME AND TITLE OF PERSON PREPARING REPORT: (PLEASE TYPE OR PRINT) **NAME:** **TITLE:**	**SIGNATURE OF PERSON PREPARING REPORT:**
PERSON PREPARING REPORT CONTACT INFORMATION: **TELEPHONE NUMBER:** **EMAIL ADDRESS:**	**DATE:**