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

**Division of Aging and Adult Services**

**Community Evaluation**

**Identifying Information**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** | **First Name** | **Middle Initial** | **Alias** |
|       |       |       |       |
| **Date of Birth** | **Age** | **Gender** | **Race** |
|       |       |  |  |

**Social Security #:**

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

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

**Telephone Number:**       **Telephone number of current location:**

Current Living Arrangement:  Length of stay at this address:

Address or driving directions:

Address of Current Living Arrangement, if different from residence address:

Length of stay at current location:

Education Level (highest level completed):

Able to read? [ ]  Yes [ ]  No Able to write? [ ]  Yes [ ]  No

History of APS reports? [ ]  Yes [ ]  No

If yes, provide dates of previous APS reports (Within last two years)

|  |
| --- |
| Click or tap to enter a date. |
| Click or tap to enter a date. |
| Click or tap to enter a date. |
| Click or tap to enter a date. |

Were photos taken? [ ]  Yes [ ]  No If, yes, provide location of photos in record:

Same perpetrator? [ ]  Yes [ ]  No

Religious preference:

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

**History of Reports:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Date** | **Time** | **AM** | **PM** |  |
| Date of the Report |       |       | [ ]  | [ ]  |  |
| Report was initiated |       |       | [ ]  | [ ]  |  |
| First face to face contact with adult |       |       | [ ]  | [ ]  |  |
| First private interview with adult |       |       | [ ]  | [ ]  |  |
| Initial notice to reporter |       |       | [ ]  | [ ]  | Written [ ] Verbal [ ]  |
| Final notice to reporter |       |       | [ ]  | [ ]  | Written [ ] Verbal [ ]  |
| Date of case decision |       |       | [ ]  | [ ]  |  |
| Dates of required notices (as needed) |       |       | [ ]  | [ ]  | DA |
| Dates of required notices (as needed) |       |       | [ ]  | [ ]  | LE |
| Dates of required notices (as needed) |       |       | [ ]  | [ ]  | DHSR [ ] Administrator [ ]  |
| Dates of other notices (as needed) |       |       | [ ]  | [ ]  | DMA [ ] AHS [ ]  |
| 5026 completed and submitted |       |       | [ ]  | [ ]  |  |
| 5027 completed for 202 services |       |       | [ ]  | [ ]  |  |

**Type of alleged maltreatment:**

[ ]  Abuse causing pain/injury [ ]  Abuse [ ]  Caretaker neglect

[ ]  Self neglect [ ]  Exploitation of person’s assets [ ]  Exploitation of person

[ ]  Other

At substantial risk: [ ]  Yes [ ]  No Specify type below:

**Summary of Allegations:**

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

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

|  |  |
| --- | --- |
| Dates | Efforts to resolve explained below |
| Click or tap to enter a date. |       |
| Click or tap to enter a date. |       |
| Click or tap to enter a date. |       |
| Click or tap to enter a date. |       |

Did a life-threatening situation exist? [ ]  Yes [ ]  No

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

**SOCIAL SUPPORT**

**Household composition**

|  |  |  |  |
| --- | --- | --- | --- |
| Names | Age | Relationship | Assistance Provided |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Family and significant others outside the home (friends, neighbors, church, etc.)**

|  |  |  |  |
| --- | --- | --- | --- |
| Names | Age | Relationship | Type/Frequency of Contact |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Ask the following questions to assess caretaker support status**

|  |  |
| --- | --- |
| When there is a problem who do you call first? |       |
| Who is helping you now and what do they do? |       |
| How do you contact them? |       |
| How do you feel about what and how much your helpers are doing? |       |
| How do you think they feel? |       |
| Who do you come in contact with on a typical day? |       |
| Do you receive any help from any community agencies? | [ ]  Yes [ ]  No |
| What is the agency and who is your contact person? |       |

**Community Agency Information**

|  |  |  |
| --- | --- | --- |
| **Agency** | **Contact person** | **Service(s) provided** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

**Based on the above information, does the adult have a caretaker?** **[ ]  Yes** **[ ]  No**

A caretaker is one who has the comprehensive hands on day-to-day responsibility of the disabled

adult.

If yes, give the following applicable information about the primary caretaker.

|  |  |
| --- | --- |
| Name |       |
| Address |       |
| Relationship to the adult |       |
| Contact number |       |

**Is the caretaker any of the following:**

 Date of appointment/authority given:

|  |  |
| --- | --- |
|  [ ]  Legal Guardian | Click or tap to enter a date. |
|  [ ]  Guardian of Person | Click or tap to enter a date. |
|  [ ]  Guardian of Estate | Click or tap to enter a date. |
| Power of Attorney (Identify type)  | Registered in: [ ]  County [ ]  State  |
|  [ ]  General | Click or tap to enter a date. |
|  [ ]  Durable | Click or tap to enter a date. |
|  [ ]  Health care | Click or tap to enter a date. |
|  [ ]  Representative Payee for | Click or tap to enter a date. |
|  [ ]  Living Will  | Click or tap to enter a date. |

If someone else other than the primary caretaker has legal guardianship, power of attorney, payee for the adult, or other caretaking responsibility, list their name, address, telephone number and type of authority/responsibility below:

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

The following are indicators of maltreatment. The presence of these “red flags” indicate a high-risk of maltreatment and require that information is needed to determine the effect it has on the adult’s safety. N/A if there is no caretaker.

**Caretaker Indicators If yes, impact on adult**

|  |  |  |
| --- | --- | --- |
| Alcohol/drug misuse | [ ] Yes [ ] No |  |
| Mental/emotional impairment | [ ] Yes [ ] No |  |
| Financially dependent on adult | [ ] Yes [ ] No |  |
| No contacts outside the home | [ ] Yes [ ] No |  |
| Blaming the adult/hypercritical | [ ] Yes [ ] No |       |
| Deterioration of physical health | [ ] Yes [ ] No |       |
| Reluctance to provide care | [ ] Yes [ ] No |       |
| Inexperienced/unrealistic expectations of adult/self | [ ] Yes [ ] No |       |

**Family Systems Indicators If yes, impact on adult**

|  |  |  |
| --- | --- | --- |
| Lack of family support | [ ] Yes [ ] No |       |
| Disagreement over shared responsibility | [ ] Yes [ ] No |       |
| History of violence in handling stress or conflict | [ ] Yes [ ] No |       |
| Economic, financial problems  | [ ] Yes [ ] No |       |
| Overcrowding | [ ] Yes [ ] No |       |
| Marital conflict | [ ] Yes [ ] No |       |
| Intergenerational conflict | [ ] Yes [ ] No |       |
| **Comments:** |  |
|  |

**ENVIRONMENTAL**

**Adult’s living arrangement:**

**Type of residence:**

**If other, specify below**:

**Environmental Risk Factors (Check all that apply)**

|  |  |  |
| --- | --- | --- |
| [ ]  Threatened eviction | [ ]  No electricity  | [ ]  Household areas inaccessible |
| [ ]  Inadequate heating/cooling source | [ ]  Accumulated debris | [ ]  No safe water supply |
| [ ]  Deteriorating structure | [ ]  No water  | [ ]  Unsanitary conditions |
| [ ]  Neighborhood | [ ]  Animal infested living quarters | [ ]  Telephone |
| [ ]  Accessibility issues | [ ]  No food storage facilities | [ ]  Transportation |
| [ ]  Mobility barriers | [ ]  Fire hazards | [ ]  Internal hazards |
| [ ]  External hazards | [ ]  Inadequate toilet facilities  | [ ]  Others please specify below: |
| [ ]  Insect infested living quarters |  |       |

**Level of Endangerment**

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

Comments/Description (if needed):

Does the home have a working smoke detector? [ ]  Yes [ ]  No

Describe any environmental risk factors and the adult’s understanding of risk factors:

**ECONOMIC ASSESSMENT**

**Adult’s financial affairs are managed by:**

|  |  |
| --- | --- |
| Self | Other: Name/relationship |
|       |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Monthly Income** |  | **Monthly Expenses** |  | **Benefits Received** |
| Social Security |       | Rent |       | [ ]  Medicare Part A |
| SSI |       | Mortgage |       | [ ]  Medicare Part B |
| VA Pension |       | Utilities |       | [ ]  Medicaid |
| RR Retirement |       | Taxes |       | [ ]  Other Health Insurance |
| Public assistance |       | Medicine |         | [ ]  FNS $      |
| Interest/dividends |       | Life insurance |       |       |
| Pension |       | Health insurance |       |       |
| Retirement |       | Medical expenses |       |       |
| Other: |       | Other: |       |       |
| Total |       | Total |       |       |

**Assets**

|  |  |  |
| --- | --- | --- |
| **Assets** | **Value** | **Description/location if known** |
| Checking account |       |       |
| Savings account |       |       |
| Real estate |       |       |
| Securities |       |       |
| Personal |       |       |
| Other: |       |       |

Does the adult experience financial problems in meeting basic needs such as: (check all that apply)

|  |  |  |
| --- | --- | --- |
| [ ]  Food | [ ]  Power | [ ]  Fuel |
| [ ]  Shelter | [ ]  Medicine | [ ]  Clothing |
| [ ]  Other | [ ]  Other | [ ]  Other |

Adult/Family’s perception of adult’s financial situation and ability to manage finances:

**MENTAL/EMOTIONAL FUNCTIONING**

**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 |
|  | Does the adult know in whose home 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 know his/her relationship to significant others? | [ ] Yes | [ ] No | [ ] Non-Responsive | [ ] Refused to Answer |

**Memory**

Assess distant, recent and immediate memory. Resources to many of the other questions asked during the interview can be used to complete the rating. 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:**

**Judgment**

Assess the clients’ response to both routine and emergency situations. Enter one of the responses below.

1. **Good decision-making/problems solving skills**

**2. Mild deficient: can handle everyday decisions/problems, but not good with complex issues**

**3. Moderate deficient: questionable decision-making/problem solving skills, may be able to handle some routine decisions**

**4. Severe deficient; difficulty with some 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; cannot open medicine bottle; in–home aide does not come to the home; stranger knocks on the door; money is low and purchasing decisions must be made; cannot read medicine bottle instructions) and assess ability to gather and accept facts, weigh advice, solve problems, make decisions, and understand their consequences.  |
|  | **Additional information below:** |
|  |  |

|  |  |
| --- | --- |
|  | **Emergency:** Describe several emergency situations that may occur (e.g. power goes out; no money to buy food/medicine; client falls; house/appliance fire) and assess ability to gather and accept facts, weigh advice, discern unsafe/threatening situations, make decisions and understand their consequences. |
|  | **Additional information below:** |
|  |  |

|  |  |
| --- | --- |
|  | **Arithmetic:** The adult’s ability to handle simple arithmetic tasks provides an indication of mental function, may distinguish between depression and dementia, and is linked to the capacity 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 client to perform simple tasks such as subtracting by twos from twenty. Enter one of the responses below to indicate the adult’s arithmetic ability. |
|  | **Additional information below:** |
|  |  |

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

**Arithmetic Ability** (Indicate arithmetic ability from chart above):

**Mental/Emotional Assessment**

|  |  |  |
| --- | --- | --- |
| **Diagnosis/Symptom** | **\*Source** | **Notes (e.g., onset, severity, functional impact, history, untreated conditions, needs professional assessment, current treatment)** |
| Aggressive/abusive behavior |  |       |
| Agitation/anxiety/panics attacks |  |       |
| Change in activity levels (sudden/extreme) |  |       |
| Change in appetite |  |       |
| Cognitive impairment/memory impairment |  |       |
| Intellecutal and Developmental Disability (IDD) |  |       |
| Hallucinations/delusions |  |       |
| Inappropriate affect (flat or incongruent |  |       |
| Impaired judgement |  |       |
| Mental anguish |  |       |
| Mental illness |  |       |
| Orientation impaired |  |       |
| Persistent sadness |  |       |
| Sleep disturbances |  |       |
| Substance abuse |  |       |
| Thoughts of death/suicide |  |       |
| Wandering |  |       |
| Other |  |       |

**\*Source Codes**

**C**=Client statement **M**=FL2, MD, other medical professionals

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

**O**=Other – specify

Describe any memory impairment:

**Activities of Daily Living (basic and instrumental)**

**ADL Tasks**

|  |  |  |  |
| --- | --- | --- | --- |
| **Task** | **Needs Assistance** | **Provided by** | **Source Code** |
| Ambulation |       |       |  |
| Bathing |       |       |  |
| Eating |       |       |  |
| Grooming |       |       |  |
| Toileting |       |       |  |
| Transfer to/from bed |       |       |  |
| Transfer to/from chair |       |       |  |
| Transfer into/out car |       |       |  |

**IADL Tasks**

|  |  |  |  |
| --- | --- | --- | --- |
| **Task** | **Needs Assistance** | **Provided by** | **Source Code** |
| Home maintenance |       |       |  |
| Housework |       |       |  |
| Laundry |       |       |  |
| Meal preparation |       |       |  |
| Money management |       |       |  |
| Shopping/errands |       |       |  |
| Telephone use |       |       |  |
| Transportation |       |       |  |

**\*Source Code**

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

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

**PHYSICAL HEALTH ASSESSMENT**

|  |  |  |
| --- | --- | --- |
| **DIAGNOSIS/SYMPTOMS** | **\*Source Code** | **Notes (e.g., onset, severity, functional impact, history, untreated conditions, needs professional assessment, current treatment)** |
| Arthritis/osteoporosis/gout |  |       |
| Asthma/emphysema/other respiratory |  |       |
| Bladder/urinary problems or incontinence |  |       |
| Bowel problems or incontinence |  |       |
| Cancer |  |       |
| Dental problems |  |       |
| Diabetes |  |       |
| Dizziness/falls |  |       |
| Eye disease |  |       |
| Hypertension/high blood pressure |  |       |
| Heart disease/angina  |  |       |
| Kidney disease/renal failure |  |       |
| Liver disease |  |       |
| Multiple sclerosis/muscular dystrophy/cerebral palsy |  |       |
| Pain |  |       |
| Paraplegia/quadriplegic/spinal problems |  |       |
| Parkinson’s Disease |  |       |
| Rapid weight gain/loss |  |       |
| Seizures |  |       |
| Shortness of breath/persistent cough |  |       |
| Skin condition |  |       |
| Speech impairment |  |       |
| Stroke |  |       |
| Other |  |       |

**\*Source Code**

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

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

**O**=Other collateral

**Medical Treatment**

|  |  |
| --- | --- |
| Source/location of medical care and treatment |       |
| Date of last medical visit | Click or tap to enter a date. |
| Date APS worker contacted medical provider | Click or tap to enter a date. |
| Physician name |       |

**Findings:**

Has adult recently been hospitalized? [ ]  Yes [ ]  No If yes, date of most recent hospitalization:

If yes, give reason for hospitalization below:

Medical records attached: [ ]  Yes [ ]  No

**Medications**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of Medication** | **OTC** | **Prescription/ Date filled** | **Dosage/****Administration** | **Prescribing MD** | **Purpose** | **Compliant** |
|      | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |
|       | [ ]  | Click or tap to enter a date. |       |       |       | [ ]  |

**Note:** **Additional medications may be noted on added sheet**

**Medication Assessment**

|  |  |
| --- | --- |
| Can client identify prescribed medication and purposes? | [ ]  Yes [ ]  No |
| Able to take medication in prescribed doses at proper time? | [ ]  Yes [ ]  No |
| Can prepare and take medications with reminder? | [ ]  Yes [ ]  No |
| Can take medication if assisted with preparation? | [ ]  Yes [ ]  No |
| Refuses to take medications as prescribed  | [ ]  Yes [ ]  No |
| Unable to take medications correctly without assistance | [ ]  Yes [ ]  No |

If adult needs assistance with medication, is he/she receiving assistance needed? [ ]  Yes [ ]  No

If yes, from whom?

If no, why is he/she not receiving the medication assistance?

**Collateral Contact Information**

Collateral contacts **MUST** be made with others who have pertinent information or knowledge of the adult’s functioning and/or the allegations of mistreatment. Collaterals can include but are not limited to relatives, friends, neighbors, medical/mental health professionals, individuals who the adult mentions that may have pertinent information, law enforcement, etc. (Please add additional pages as needed.)

|  |  |
| --- | --- |
| Date of Contact: | Click or tap to enter a date. |
| Name of Collateral |       |
| Relationship to Adult |       |
| Address (Optional) |       |
| Telephone Number |       |
| Information Given |       |

|  |  |
| --- | --- |
| Date of Contact: | Click or tap to enter a date. |
| Name of Collateral |       |
| Relationship to Adult |       |
| Address (Optional) |       |
| Telephone Number |       |
| Information Given |       |

|  |  |
| --- | --- |
| Date of Contact: | Click or tap to enter a date. |
| Name of Collateral |       |
| Relationship to Adult |       |
| Address (Optional) |       |
| Telephone Number |       |
| Information Given |       |

|  |  |
| --- | --- |
| Date of Contact: | Click or tap to enter a date. |
| Name of Collateral |       |
| Relationship to Adult |       |
| Address (Optional) |       |
| Telephone Number |       |
| Information Given |       |

**Contact With Adult During APS Evaluation:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Contact | Type Contact (e.g., HV, TC, OV) | Purpose of Contact | Others Present |
| Click or tap to enter a date. |       |       |       |
| Click or tap to enter a date. |       |       |       |
| Click or tap to enter a date. |       |       |       |
| Click or tap to enter a date. |       |       |       |
| Click or tap to enter a date. |       |       |       |
| Click or tap to enter a date. |       |       |       |
| Click or tap to enter a date. |       |       |       |

**Evidence of Abuse, Neglect or Exploitation or a 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*).**

|  |  |  |
| --- | --- | --- |
| **[ ]  Hitting, slapping, or kicking** | **[ ]  Objects thrown at adult** | **[ ]  Demonstrates fear of the caretaker** |
| **[ ]  Broken bones or wounds**  | **[ ]  Verbal assaults, threats** | **[ ]  Willful deprivation** |
| **[ ]  Multiple, severe bruises, burns or welts** | **[ ]  Prolonged interval between injury and treatment** |  |
| **[ ]  Restrained, locked in, isolated** | **[ ]  Threatened/injured with weapon** |  |
| **[ ]  Non-consenting sexual activity** | **[ ]  Injuries in odd places** |  |

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

**Level of Endangerment**

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

Comments/Description (if needed):

**Neglect-check all conditions present**

|  |  |
| --- | --- |
| [ ]  Dirt, fleas, lice on person  | [ ]  Inadequate clothing |
| [ ]  Malnourished or dehydrated | [ ]  Decayed teeth |
| [ ]  Fecal/urine smell  | [ ]  Bedsore or other ulcers |
| [ ]  Doesn’t get/take medications | [ ]  Lack of glasses/hearing aid or other prosthetic devices |
| [ ]  Medical/psychiatric needs  | [ ]  Does not get to medical doctor |
| [ ]  Homeless | [ ]  No utilities (specify)       |
| [ ]  Other (specify)       | [ ]  Untreated medical needs: (specify)       |

**Level of Endangerment**

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

Comments/Description (if needed)

**Self Endangering Behaviors- check all that apply**

|  |  |
| --- | --- |
| [ ]  Suicidal acts  | [ ]  Refuses medical treatment |
| [ ]  Self-inflicted injuries  | [ ]  Threats of suicide |
| [ ]  Frequenting dangerous places | [ ]  Abuse of medications [ ]  RX [ ]  OTC |
| [ ]  Refuses MH treatment | [ ]  Refuses substance abuse treatment |
| [ ]  Wandering | [ ]  Denial of problems |
| [ ]  Other (specify)       | [ ]  Not applicable |
| [ ]  Substance abuse |  |

**Level of Endangerment**

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

Comments/Description (if needed)

**Exploitation of Assets**

|  |  |
| --- | --- |
| [ ]  Unexplained disappearance of funds or valuables |  [ ]  Chronic failure to pay for services and/or bills |
| [ ]  Excessive payment for care and/or services  |  [ ]  Transfer of other assets |
| [ ]  Transfer of real property  |  [ ]  Changes in Payee or Power of Attorney |
| [ ]  Sudden appearance of previously uncaring relatives or friends |  [ ]  Inappropriate use of adult’s telephone, food or other resources |
| [ ]  Significant debt |  [ ]  Parasitic relationship of others toward adult |
| [ ]  Caretaker refuses to use adult’s funds to meet essential needs |  [ ]  Adult unaware of income amount |
| [ ]  Depleted bank account |  [ ]  Not applicable |
| [ ]  Other:       |

**Level of Endangerment**

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

Comments/Description (if needed):

**Exploitation of the Person**

|  |  |  |
| --- | --- | --- |
| [ ]  Forced to work without pay | [ ]  Sexual exploitation | [ ]  Not applicable |
| [ ]  Other (specify) |  |

**Level of Endangerment**

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

Comments/Description (if needed):

**Summary of adult’s understanding and willingness to accept assistance as indicated above:**

**Adult previously victimized?**

**Alleged Perpetrator Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Current alleged perpetrator name |       | Date of birth |       |
| Address |       | Telephone number |       |
| Relationship |       | Date of contact |       |

Alleged perpetrator’s contact with client:

Alleged perpetrator’s employment:

Alleged perpetrator’s reaction to APS worker:

Summary of perpetrator’s statement concerning APS allegations:

Criminal records checked (*optional*) [ ]  Yes [ ]  No Enter Date: Click or tap to enter a date.

Relevant information obtained:

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 a lack of a thorough evaluation, lack of staffing resources, lack of formal resources, lack of access to the court system, or prior history with the 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? [ ]  Yes [ ]  No

b. Is the person emotionally mature, trustworthy, reliable, and have a history of using good judgment and sound thinking? [ ]  Yes [ ]  No

c. Does this identified person understand the protective services needs and willing to make sure that all the needs are met? [ ]  Yes [ ]  No

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? [ ]  Yes [ ]  No

e. Are there any legal or relational issues between the identified person and the victim that may present as problematic, i.e., victim had been an abusive parent to identified person? [ ]  Yes [ ]  No

**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 well-being.

Has a caretaker? [ ]  Yes [ ]  No

**ABUSE:**

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

Has been neglected by their caretaker? [ ]  Yes [ ]  No If yes, state how:

Is self-neglectful? [ ]  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.

If services were offered and accepted, was DSS-5027 completed for APS Mobilization (204)?

[ ]  Yes [ ]  No

Date submitted: Click or tap to enter a date.

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

Allegations 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 a substantial risk[ ]  Yes [ ]  No | Services offered[ ]  Yes [ ]  No[ ]  Accepted [ ]  Refused | Adult/Client referred to:      |

|  |  |
| --- | --- |
|       | Click or tap to enter a date. |
| **Signature of APS Social Worker** | **Date** |
|       | Click or tap to enter a 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.)**