Adult Protective Services Referral

Date of Referral:

Individual Making Referral Name:
Address:
Phone Number:

Adult Victim Information:

Name:	**DOB or Age**:
Marital Status: ☐ Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed	
Address:	**Phone number**:
Current location:	**Expected length of stay**:
When incident occurred:	**Did you or others witness the incident?**
Income source(s): ☐ SSA $_____ ☐ VA $_____ ☐ Other: _____	
☐ **Guardian** – Contact Name: _____ Contact Ph Number: _____ ☐ **Rep Payee** – Contact Name: _____ Contact Ph Number: _____ ☐ **POA-HC** ☐ Yes ☐ No ☐ Activated? Agent: _____ Ph Number: _____ ☐ **POA-F** ☐ Yes ☐ No ☐ Activated? Agent: _____ Ph Number: _____	
Medical Diagnosis: ☐ Alzheimer's ☐ Dementia ☐ Cognitive delays ☐ Mental illness ☐ Other (specify)_____	
Reason for referral (Please provide as much detail possible):	

Known additional contacts relevant to the victim:

Name:	Address:	Phone Number:

Reason for APS involvement needed		
☐ Emotional Abuse	☐ Emergency Protective Placement	☐ Financial Abuse
☐ Neglect by other(s):	☐ Physical Abuse	☐ Self-neglect
☐ Sexual abuse	☐ Treatment without consent	☐ Other:

Alleged abuser(s) information (if applicable):

Name and Relationship:	Address:	Phone number: