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 ☐ Divorce ☐ Widowed	
Address:	**Phone number**:
Current location:	**Expected length of stay**:
When the 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: _____ ☐**Long Term Care Enrollment** ☐ Yes ☐No Name of Agency: _____	
Medical Diagnosis: ☐ dementia (ex: Alzheimer's) ☐ developmental disability ☐ mental illness ☐ other incapacities (ex: traumatic brain injury) ☐ 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: