**Date of Referral**

**I.Type of Referral**

**Adult at Risk Investigation Elder at Risk Investigation Court Referral**

[ ] Neglect ([ ] self [ ] other) [ ] Neglect ([ ] self [ ] other) [ ] Guardianship [ ] Abuse(physical/ sexual) [ ] Abuse(physical/ sexual) [ ] Prot. Placement [ ] Financial Exploitation [ ] Financial Exploitation [ ] Review of Conduct

 [ ] Other

Alleged perpetrator:       Relationship to victim:

 Perpetrator Contact Information (address/Phone):

**II. Member Information**

|  |  |  |
| --- | --- | --- |
| **Name** | **DOB** | **Telephone** |
| **Address** | **City** | **State/ Zip Code** |
| **County of Residence** | **County of Responsibility** | **Veteran?****[ ] Yes** **[ ] No** **[ ] Unknown** |
| **Race**[ ] **White/Caucasian** **[ ] American Indian****[ ]  Black/African American [ ] Asian** **[ ] Native Hawaiian/Pacific Islander****[ ] Unknown** | **Ethnic Origin****[ ] Hispanic****[ ] Not Hispanic****[ ] Unknown** |
| **Name of Decision Maker; Relationship to Member****;****Contact Information** | **Type of Decision Maker****[ ] Power of Attorney; Activated: [ ] Yes [ ] No****[ ] Durable Power of Attorney****[ ] Guardian of Person** **[ ] Guardian of Estate****[ ] Other:**  |

**III. Reason for the Referral**:

**Summary of Concerns and Reason for Referral (*include dates and attempts at service intervention and specific risks and safety concerns to the member*)**

**What Interventions or services have been tried or offered to address the concern(s)? *(include other team members or agency resources consulted)***

**Summary of safety/risk concerns to the client (*include current safety plan or placement*).**

**MCO/IRIS Documentation available to support this APS referral include:**

**[ ]  Service/Care Plan [ ]  Risk Assessment [ ]  SHC Assessment [ ]  Behavioral Support Plan [ ] Psychological Evaluation [ ] Examining Physicians Report (EPR) [ ] Other:**

**IV. Referral Contact Information**

**Agency Member is enrolled:       Program:**

**Date of Enrollment:**

**Case Manager Name:       Phone:       Fax:**

**Rn Case Manager Name:       Phone:**

**Supervisor Name:       Phone:**

**Supervisor Signature:** **Date:**

*Completed APS Referral should be scanned to: (Insert Email address) You will receive an email response as confirmation that the referral has been received by APS. The APS Supervisor will determine need for intervention on all referrals. \*\* Use of the APS referral is not appropriate for client emergencies or persons with immediate health and safety concerns.*