**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.*