



PENNSYLVANIA DEPARTMENT OF AGING

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGING
Harrisburg, Pa. 17101

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AGING PROGRAM DIRECTIVE

SUBJECT: REQUIRED STANDARD FORMS FOR PROTECTIVE SERVICES

TO: EXECUTIVE STAFF PA COUNCIL ON AGING
 DIVISION OF FIELD OPERATIONS PA STATE ASSOCIATION
 AREA AGENCIES ON AGING COUNTY COMMISSIONERS
 AoA REGION III COMPTROLLER

FROM: Linda M. Rhodes
 LINDA M. RHODES
 SECRETARY
 DEPARTMENT OF AGING

PURPOSE: The purpose of this Aging Program Directive (APD) is to disseminate three (3) forms which agencies providing Protective Services to older adults under Act 1987-79 will be required to utilize.

BACKGROUND: The Department has developed three (3) standard forms to insure uniformity in receiving reports of need for Protective Services, recording investigative activities, and documenting staff agreement to protect the confidentiality of Protective Services information. Copies of the forms listed below are provided for duplication and utilization by Protective Services providers.

1. Confidential Report of Need for Protective Services
2. Older Adults Protective Services Investigation Report
3. Confidentiality Statement

The Protective Services caseworker training curriculum provides instruction on the completion and utilization of the required standard forms. Therefore, this APD will be restricted to a concise statement on the appropriate use of each form.

1. Confidential Report of Need for Protective Services

This form is to be completed only by individuals who have received the required training for receiving, recording, screening, and referring reports set forth at §15.124 of the Protective Services Regulations. It is to be completed as set forth at §15.24 of the regulations for every incoming report of need for Protective Services and used to systematically collect information, screen and categorize reports, and note findings of the investigation. Completed report forms are confidential information and must be handled in accordance with §15.101-15.105 of the Protective Services Regulations.

2. Older Adults Protective Services Investigation Report

This form is to be completed only by individuals who have received the required training for Protective Services caseworkers set forth at §15.121-15.127 of the Protective Services Regulations. It will be used to document activities in the required investigation of every report of need for Protective Services. Additional information (e.g. signed statements, photographs, etc.) may be attached to the form. Upon completion of the investigation, the findings (i.e. substantiated, unsubstantiated) should be recorded on both the Report of Need and the Investigation Report. Completed investigation forms are confidential information and must be handled in accordance with §15.101-15.105 of the Protective Services Regulations.

3. Confidentiality Statement

This form is to be completed and signed by all Protective Services caseworkers, supervisors, stand-by or clerical staff. Prior to execution of the form, the employee should be fully advised of confidentiality provisions and penalties set forth at §15.101-15.105 of the Protective Services Regulations. Subsequent to execution, the form should be maintained in the employee's personnel file.

It should be noted that standard forms have not been developed for client assessments, service plans, informed consent, refusal of protective services, emergency petitions, access petitions, or notification of clients or perpetrators. The agency should continue to use those forms currently in use or develop forms which comply with the regulations and meet local needs.

CONFIDENTIAL
 REPORT OF NEED FOR PROTECTIVE SERVICES
 (INFORMATION RECORDED AS REPORTED)

DATE OF REPORT: _____ TIME OF REPORT: _____

PERSON COMPLETING FORM: _____
 (SIGNATURE, NAME, TITLE)

PERSON MAKING REPORT: _____ PHONE #: _____
 (NAME, ADDRESS)

PROBLEM: _____

(DESCRIPTION OF INCIDENT WHICH PRECIPITATED THE REPORT)

WHEN WAS THE CLIENT LAST SEEN? _____ BY WHOM? _____

WHERE IS CLIENT NOW? _____

IS CLIENT IN A LIFE THREATENING SITUATION? _____

DOES CLIENT KNOW THAT REPORT HAS BEEN MADE? _____

NAME OF CLIENT: _____ SEX: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

LANGUAGE(S) SPOKEN: _____

PHYSICAL AND MENTAL STATUS OF CLIENT: _____

NATURE AND EXTENT OF NEED FOR PROTECTIVE SERVICES: _____

CAREGIVER: _____ PHONE #: _____
 (NAME, ADDRESS)

REPORTED
 CLIENT CONDITION CHECKLIST
 (CHECK APPROPRIATE BOXES)

REPORTED PHYSICAL CONDITION AND HEALTH:	YES	NO	UNKNOWN
PHYSICAL TRAUMA (E.G., BRUISES, CUTS, BURNS)			
SIGNS OF SEXUAL ABUSE (E.G., DISCOMFORT, BRUISES IN GENITAL AREA)			
POOR PERSONAL HYGIENE (E.G., DIRTY, ODOROUS, POOR DENTAL CARE)			
POOR NUTRITIONAL STATUS (E.G., MALNOURISHED, DEHYDRATED, WEIGHT LOSS)			
UNMET PERSONAL NEEDS (E.G., LACK OF FALSE TEETH, EYEGLASSES, HEARING AID)			
MEDICATION MISUSES (E.G., UNDERMEDICATED, SUBSTANCE ABUSE)			
UNTREATED MEDICAL CONDITION (E.G., ULCERATIONS, BEDSORES)			
FUNCTIONAL LIMITATIONS (DESCRIBE UNDER COMMENTS)			

COMMENTS: _____

REPORTED MENTAL/EMOTIONAL CONDITION:	YES	NO	UNKNOWN
DISORIENTED (E.G., TO PERSON, PLACE, TIME)			
UNABLE TO COMMUNICATE AND/OR COMPREHEND			
APPEARS ANXIOUS OR FEARFUL			
SUICIDAL TALK/ACTIONS			
HALLUCINATIONS (E.G., HEARING VOICES, SEEING NON-EXISTENT THINGS)			
FEELS THREATENED OR INTIMIDATED			
CONFUSION (E.G., MEMORY LOSS, WANDERING)			
COMMENTS:			

REPORTED PHYSICAL ENVIRONMENT:	YES	NO	UNKNOWN
INADEQUATE UTILITIES (E.G., HEAT, PLUMBING)			
SAFETY HAZARDS (E.G., FIRE DANGER, LEAKY ROOF)			
ARCHITECTURAL BARRIERS (E.G., INACCESSIBLE, BATHROOM, STAIRWAY)			
INSECT/PEST INFESTATION			
PET/ANIMAL PROBLEM (E.G., OVERPOPULATION, INADEQUATE CARE)			
GARBAGE/TRASH ACCUMULATION			
COMMENTS:			

REPORTED FINANCIAL PROBLEMS:	YES	NO	UNKNOWN
MISSING ASSETS (E.G., CHECKS, CASH, PERSONAL PROPERTY)			
MISMANAGEMENT OF FUNDS (E.G., UNPAID BILLS, UTILITY SHUTOFFS)			
UNEXPECTED CHANGE OF NAME ON ACCOUNTS			
DEPLETED BANK ACCOUNT WITH NO REASON			
OTHER UNUSUAL FINANCIAL ARRANGEMENTS			

COMMENTS: _____

REPORT CATEGORY	WHEN TO REFER TO PROTECTIVE SERVICES WORKER
<u>EMERGENCY</u>	IMMEDIATELY
<u>PRIORITY</u>	IMMEDIATELY
<u>NON-PRIORITY</u>	NORMAL BUSINESS HOURS
<u>ANOTHER PSA</u>	DEPENDS ON OTHER CATEGORY
<u>NO NEED FOR PROT SERV</u>	NORMAL BUSINESS HOURS

COMPLETED REPORT FORM RECEIVED BY PROT SERV WORKER: DATE: _____ TIME: _____

REPORT CATEGORY: CONFIRMED _____ CHANGED TO: EMERGENCY _____ OTHER PSA
PRIORITY _____ NO NEED
NON-PRIORITY _____ FOR PROT
SERVS

(SIGNATURE, NAME, TITLE) _____

RESULTS OF INVESTIGATION: SUBSTANTIATED
 UNSUBSTANTIATED

B. EVIDENCE OF SERIOUS
EMOTIONAL ABUSE

C P U N

OBSERVATIONS
(NOTE SOURCES AND NATURE OF
CONFIRM. OR OTHER EVIDENCE)

	C	P	U	N	
1. Sleep Disturbance	---	---	---	---	
2. Worried, Anxious	---	---	---	---	
3. Irritable, Easily Upset	---	---	---	---	
4. Changed Eating Habits	---	---	---	---	
5. Loss of Interest	---	---	---	---	
6. Threatened, Intimidated, Fearful	---	---	---	---	
7. Suicidal Talk, Wishes	---	---	---	---	
8. Frequent Shaking, Trembling or Crying	---	---	---	---	
9. Disoriented (Person, Place, Time)	---	---	---	---	
10. Appears Confused	---	---	---	---	
11. Unable to Communicate	---	---	---	---	
12. Unable to Comprehend	---	---	---	---	
13. Hallucinations	---	---	---	---	
14. Other	---	---	---	---	

ABUSIVE ACTIONS
(EMOTIONAL AND PHYSICAL)

C P U N

OBSERVATIONS
(NOTE SOURCES AND NATURE OF
CONFIRM. OR OTHER EVIDENCE)

	C	P	U	N	
1. Insulted, Swore or Yelled at Victim	---	---	---	---	
2. Threatened, Coerced	---	---	---	---	
3. Confined/Isolated	---	---	---	---	
4. Attempted to Harm	---	---	---	---	
5. Threw Objects at Victim	---	---	---	---	
6. Pushed, Grabbed Victim	---	---	---	---	
7. Struck or Kicked Victim	---	---	---	---	
8. Threatened Victim With Weapon	---	---	---	---	
9. Injured Victim With Weapon	---	---	---	---	
10. Other	---	---	---	---	

D. EVIDENCE OF SERIOUS
NEGLECT
(BY SELF OR CAREGIVER)

C P U N

OBSERVATIONS
(NOTE SOURCES AND NATURE OF
CONFIRM. OR OTHER EVIDENCE)

1. Dirt, Fleas or Lice on Person	---	---	---	---	
2. Skin Rash	---	---	---	---	
3. Sores	---	---	---	---	
4. Malnourished	---	---	---	---	
5. Dehydrated	---	---	---	---	
6. Inappropriate Clothing	---	---	---	---	
7. Fecal/Urine Smell	---	---	---	---	
8. Untreated Medical Problem	---	---	---	---	
9. Other	---	---	---	---	

E. NEGLECT FOR ACTIONS
(FAILURE OF CAREGIVER
TO PROVIDE)

C P U N

OBSERVATIONS
(NOTE SOURCES AND NATURE OF
CONFIRM. OR OTHER EVIDENCE)

1. Adequate Food	---	---	---	---	
2. Adequate Heat	---	---	---	---	
3. Adequate Personal Care	---	---	---	---	
4. Adequate Supervision	---	---	---	---	
5. a. Prescribed Medication	---	---	---	---	
b. Medical Equip or Aids	---	---	---	---	
c. Other Medical Service	---	---	---	---	
6. Other	---	---	---	---	

F. FINANCIAL EXPLOITATION

C P U N

OBSERVATIONS
(NOTE SOURCES AND NATURE OF
CONFIRM. OR OTHER EVIDENCE)

1. Stolen Money/Assets Of Victim	---	---	---	---	
2. Misused Money/Assets of Victim	---	---	---	---	
3. Missing Money/Assets	---	---	---	---	
4. Recent Change in Bank Accounts	---	---	---	---	
5. Unexpected Change in Accounts	---	---	---	---	
6. Unusual Financial Arrangements	---	---	---	---	
7. Access to Accounts (e.g., joint, etc.)	---	---	---	---	
8. Fiduciary Relationships (e.g., Guardian, Power of Attorney, Rep. Payee) (List)	---	---	---	---	

Court

Date(s)

7. PHYSICAL ENVIRONMENT PROBLEMS

C P U N

OBSERVATIONS
(NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)

1. Repair	---	---	---	---	
2. Cleanliness	---	---	---	---	
3. Architectural Barriers	---	---	---	---	
4. Kitchen/Bath Facilities	---	---	---	---	
5. Living/Sleeping Area	---	---	---	---	
6. Utilities	---	---	---	---	
7. Fire Safety	---	---	---	---	
8. Pest Problems	---	---	---	---	
9. Pet/Animal Problems	---	---	---	---	
0. Garbage/Trash Accum.	---	---	---	---	
1. Other	---	---	---	---	

ART II MEDICAL INFORMATION

.. CURRENT MEDICAL CONDITIONS: () if Diagnosed

- . () _____
- . () _____
- . () _____
- . () _____
- . () _____

. RECENT HOSPITALIZATIONS:

DATES

_____	_____
_____	_____
_____	_____
_____	_____

. CURRENT MEDICAL TREATMENT/THERAPIES (BY SELF OR OTHERS):

CURRENT MEDICATIONS:

DATE NAME DOSAGE/FREQUENCY PURPOSE DOCTOR PHARMACY

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CONFIDENTIALITY STATEMENT

In assuming my responsibilities as an employee of _____
(Area Agency or

_____ in the capacity of a protective services
P. S. Subcontractor)

caseworker, protective services supervisor, protective services stand-by or

clerical staff, I, _____ hereby agree to the following:
(Name)

- (1) Treat the identity of and all information relating to the
older adults in need of protective services as confidential.
- (2) Treat the identity of and all information relating to any
person who reports or participates in an investigation under
the Older Adults Protective Services Act as confidential.

I further agree to exercise great care in protecting the _____
(Agency)

_____ records from any scrutiny by unauthorized persons. I

am fully cognizant of all confidentiality provisions and penalties for
violation of confidentiality requirements in the Older Adults Protective
Services Act and regulations associated with this Act.

I understand that any breach of this agreement shall constitute good
cause for immediate termination of employment with _____
(Agency)

and constitute a violation of the regulations promulgated by the Pennsylvania
Department of Aging.

Signed _____ Date _____