



Aging Program Directive

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Protective Services Office

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Subject: Revised Report of Need and Instructions

To: Pennsylvania Department of Aging
Area Agencies on Aging
Pennsylvania Association of Area Agencies on Aging
Pennsylvania Council on Aging

From:

Teresa Osborne
Secretary

Purpose: The purpose of this Aging Program Directive is to notify the network of the release of the revised *Report of Need* (RON) form (dated 5/1/2018).

Background: The revised RON form was developed in collaboration between the Pennsylvania Department of Aging and the Pennsylvania Association of Area Agencies on Aging (P4A) Protective Services and Guardianship Committee. The revisions made include the following: a question has been added to the RON form (1.B.4) in order to ensure that the indicated age of the individual reported to be in need of protective services is captured and documented when the exact date of birth is not known by the reporter; Social Isolation has been added as a type of emotional and mental condition of consumer (2.A.6); and a Physician's Office has been added as a type of voluntary reporter (3.A.4).

Directives: The following three revisions have been made to the RON:
Section 1: Reporter's Details: Question 1.B.3 on the current RON prompts the intake worker, or other worker who is completing the

RON, to document the alleged victim's date of birth. However, there are times when the reporter may not know or otherwise have access to the alleged victim's exact birth date. In these instances, the reporter must be asked to indicate whether the individual reported to be in need of protective services is either 18 to 59 years of age or 60 years of age or older. The answer to this question is to be recorded in question 1.B.4. If the individual's exact age becomes known during the investigation, SAMs, including the RON, can be updated to reflect this information.

Section 2: Reporter's Observations: "Social Isolation: Consumer Imposed" and "Social Isolation: Imposed by Another Person(s)" have been added as choices under question 2.A.6.

Researchers on elder abuse and neglect explain that social isolation and mental impairment are two factors that make an older adult more vulnerable to abuse. When completing the RON, "Social Isolation: Consumer Imposed" is checked when the reporter indicates that the alleged victim is socially isolated, is not connecting with family and friends, has minimal social supports, avoids engaging in social settings/activities and/or has a behavioral health condition or other condition (i.e., dementia or Alzheimer's Disease) that limits socialization.

When completing the RON, "Social Isolation: Imposed by Another Person(s)" is checked when the reporter indicates that the alleged victim is isolated by another person (i.e. another individual is restricting access to social/informal/family supports or activities and therefore is preventing the alleged victim from socializing freely).

Section 3: Reporter's Data: "Physician's Office" has been added as a type of voluntary reporter under question 3.A.4 in order to capture more specific data regarding the identity of reporters.

The new RON form (Appendix A) will be available and must be implemented beginning May 1, 2018. Failure to use this new RON form by that date will result in inaccurate and/or inadequate intake information, statistical errors and/or payment delays. The new RON form (Appendix A) and instructions (Appendix B) shall replace any and all older versions.

Attachments:

Report of Need (Appendix A)

Report of Need Instructions (Appendix B)

RON 5-1-2018

1. REPORTER'S DETAILS

1.A. CONSUMER'S INFORMATION

1. Date RON Received (MM/DD/YYYY)

____/____/____

2. Time RON Received (include AM or PM)

3. Date(s) of the incident(s) (MM/DD/YYYY)

4. LAST Name

5. FIRST Name

6. MIDDLE Initial

7. Name SUFFIX (if applicable)

1.B. CONSUMER'S DEMOGRAPHIC DATA

1. What type of communication assistance will be needed to communicate with consumer?

- Language
- Language and Mechanical
- Mechanical
- American Sign Language (ASL)
- None/Not Reported

2. Primary Language

- American Sign Language
- English
- Russian
- Spanish
- Other-Document in Notes

3. Date of Birth (DOB) (MM/DD/YYYY) (If unknown, document an indicated age range in Next Question, if DOB entered here, skip Question 1B4)

____/____/____

4. If Date of Birth is unknown, indicate the consumer's age range.

- Under Age 60
- Age 60+

5. Marital Status

- Divorced
- Married
- Single
- Separated
- Widowed
- Other-Document Details in Notes
- Unavailable/Unknown

6. Gender

- Female
- Male

7. Social Security Number (SSN) (Optional)

____-____-____

8. Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

9. Race(s)

- American Indian/Native Alaskan
- Asian
- Black/African American
- Native Hawaiian/Other Pacific Islander
- Non-Minority (White, Non-Hispanic)
- White-Hispanic
- Other-Document in Notes
- Unavailable

10. Current Living Arrangement (Include in the "Lives Alone" category, Consumers who live in AL, Dom Care, and PCH, pay rent, or have no roommate.)

- Lives Alone
- Lives with Spouse Only
- Lives with Child(ren) but not Spouse
- Lives with Other Family Member(s)
- Other-Document Details in Notes
- Don't Know

11. CONSUMER'S type of residence at time of reported event.

- Apartment
- Assisted Living (AL)
- CRR (Mental Health)
- Caretaker/Caregiver's Home
- Community Homes for Individuals with ID
- Domiciliary Care Home (DC)
- Family Living/Shared Living
- Intermediate Care Facility (ICF)
- Homeless
- Inpatient Psychiatric Facility
- Long Term Structured Residence (LTSR/MH) Mental Health
- Nursing Facility
- Own Home
- Personal Care Home (PCH)
- Other-Document Details in Notes
- Unknown

12. Identify where the incident occurred. If County is different than residence, document details in notes.

1.C. CONSUMER'S RESIDENTIAL ADDRESS INFORMATION

1. Name of facility, if residing in a facility. (If not residing in a facility, document as N/A.)

2. RESIDENTIAL Street Address (Include number of house, apartment, or room.)

3. RESIDENTIAL Street Address Second Line (if needed)

4. RESIDENTIAL City or Town (Optional and must be located within the required residential municipality.)

5. RESIDENTIAL Municipality - REQUIRED (Usually a Township or Borough where Consumer Votes, Pays Taxes.)

6. RESIDENTIAL County – REQUIRED

- Adams
- Allegheny
- Armstrong
- Beaver
- Bedford
- Berks
- Blair
- Bradford
- Bucks
- Butler
- Cambria
- Cameron
- Carbon
- Centre
- Chester
- Clarion
- Clearfield
- Clinton
- Columbia
- Crawford
- Cumberland
- Dauphin
- Delaware
- Elk
- Erie
- Fayette
- Forest
- Franklin
- Fulton
- Greene
- Huntingdon
- Indiana
- Jefferson
- Juniata
- Lackawanna
- Lancaster
- Lawrence
- Lebanon
- Lehigh
- Luzerne
- Lycoming
- McKean
- Mercer
- Mifflin
- Monroe
- Montgomery
- Montour
- Northampton

- Northumberland
- Perry
- Philadelphia
- Pike
- Potter
- Schuylkill
- Snyder
- Somerset
- Sullivan
- Susquehanna
- Tioga
- Union
- Venango
- Warren
- Washington
- Wayne
- Westmoreland
- Wyoming
- York
- Out Of State

7. CONSUMER'S Primary Telephone Number

8. DIRECTIONS to Consumer's Location (Optional)

9. NAME of Emergency Contact

10. PHONE Number of Emergency Contact

11. NAME of Primary Care Physician

12. Business PHONE Number for Primary Care Physician

1.D. CONSUMER'S POSTAL/MAILING ADDRESS INFORMATION

1. POSTAL Street Address (Include number of PO Box, street, house, apartment, OR room.)

2. POSTAL Address Second Line (if needed)

3. POSTAL City or Town

4. POSTAL State

5. POSTAL Zip Code

2. REPORTER'S OBSERVATIONS

2.A. CONSUMER'S CURRENT SITUATION

1. Identify ALL ALLEGATIONS made by the reporter. Document ALL Details provided regarding EACH ALLEGATION in the Notes section.

- Physical abuse
- Emotional abuse
- Self neglect
- Caretaker/Caregiver neglect
- Exploitation
- Abandonment
- Sexual abuse

2. Is the consumer in a life threatening situation?

- Yes
- No
- Unknown

3. Reported physical and health conditions of consumer - Document ALL Details in Notes.

- None/Not reported
- Amputation
- Arthritis
- Functional limitations
- Medication mismanagement (ie. undermedicated, substance abuse)
- Physical trauma (ie. bruises, cuts, burns, signs of sexual abuse)
- Poor personal hygiene (ie. dirty, odorous, poor dental health)
- Poor nutritional status (ie. malnourished, dehydrated, weight loss)
- Recent hospitalizations (ie. hospitalized in last 30 days)
- Unmet personal needs (ie. lack of false teeth, eyeglasses, hearing aid)
- Untreated medical condition (ie. ulcerations, bedsores)
- Other-Document Details in Notes
- Unknown

4. Type of disability(ies) reported:

- None/Not Reported
- ALS (Lou Gehrig's)
- Alzheimer's/Dementia
- Autism Spectrum Disorder
- Blind/Visually Impaired
- Brain Injury (Traumatic/Acquired)
- Chemical Dependency, including Alcohol and Substance Abuse
- DD/ID
- Deaf/Hearing Impaired
- Epilepsy
- Mental Illness

- Medical Diagnoses Leading to Physical Disability
- Physical Disability
- Speech Impairment
- Other-Document Details in Notes
- Unknown

5. Indicate the types of substance abuse:

- None/Not reported
- Alcohol
- Illegal drugs
- Misusing prescribed medications
- Other-Document Details in Notes

6. Reported emotional and mental conditions of Consumer - Document all Details in Notes.

- None/Not Reported
- Confusion (ie. memory loss, wandering)
- Disoriented (ie. to person, place, or time)
- Feels threatened or intimidated
- Hallucinations (ie. hearing voices, seeing non-existent objects or people)
- Recent suicidal talk/actions/thoughts
- Social Isolation: Consumer Imposed
- Social Isolation: Imposed by Another Person(s)
- Unable to communicate and/or comprehend
- Other-Document Details in Notes
- Unknown

7. Reported problems with the physical environment of Consumer - Document all Details in Notes.

- None/Not reported
- Architectural barriers (ie. inaccessible, bathroom, stairway)
- Garbage/trash accumulation
- Inadequate utilities (ie. heat, plumbing)
- In need of repair
- Insect/pest problem(s)
- Pet/animal problem(s) (ie. overpopulation, inadequate care)
- Safety hazard(s) (ie. fire danger, leaky roof)
- Other-Document Details in Notes
- Unknown

8. Note any dangers - Document Details in Notes.

- None/Not reported
- History of Violent Behavior in Home
- Gang Activity
- Neighborhood Dangers
- Known Drug Activity
- Pets
- Weapons
- Other-Document Details in Notes
- Unknown

9. Reported financial problems of Consumer - Document Details in Notes.

- None/Not reported
- Depleted bank account with no reason
- Mismanagement of funds (ie. unpaid bills, utility shut-offs)
- Missing assets (ie. checks, cash, personal property)
- Unexpected change of name on accounts
- Other unusual financial arrangements or relationships
- Unknown

10. Does the Consumer have assistance with legal/financial concerns?

- Yes
- No-Skip to 2.A.12
- Unknown-Skip to 2.A.12

11. If response to 2.A.10 is "Yes," check all appropriate options from list below.

- Guardian
- Informal Representative
- Lawyer
- Power of Attorney (Healthcare)
- Power of Attorney (Durable)
- Representative Payee

**12. What is the name of the Alleged Perpetrator (AP)?
(Document if N/A or Unknown)**

13. Does the Alleged Perpetrator currently have access to the Consumer/Consumer assets?

- Yes
- No
- Unknown

14. Where is the Consumer currently located?

3. REPORTER'S DATA

3.A. REPORTER'S INFORMATION

1. REPORTER'S First and Last Name

2. REPORTER'S Phone Number

3. Is this a MANDATED Report?

- Yes-Skip to 3.B
- No

4. Type of VOLUNTARY Reporter

- Alleged Perpetrator (AP)
- Area Agency on Aging (AAA)
- Anonymous
- Assisted Living Facility (AL)
- Consumer
- Domiciliary Care Home (DC)
- Family Member
- General Public
- Home Health Care Agency
- Hospital
- Law Enforcement Agency
- LTC Ombudsman
- Nursing Facility
- Personal Care Home (PC)
- Physician's Office
- Social Service
- Other-Document Details in Notes

3.B. MANDATORY REPORTERS (If report is voluntary, skip to 4.A)

1. NAME of the Organization/Facility- Mandatory Facilities CANNOT be Anonymous.

2. Type of MANDATORY Reporter

- Adult Training Facility/Vocational Program
- Birth Center (BC)-DOH
- Assisted Living Facility (AL)
- Community Homes for Individuals with ID - DPW
- Community Residential Rehabilitation Services (CRRS)-DPW

- Domiciliary Care Home (DC)
- Hospice-DOH
- Hospital LTC-DOH
- Home Care Agency-DOH

- Home Care Registry-DOH
- ICF/ID-DPW
- In-Home Direct Service Worker
- Licensed Home Health Care (HH)-DOH
- Long Term Structured Residence (LTSR)-DPW
- Nursing Home-DOH
- Older Adult Daily Living Center (OADLC)
- Personal Care Home (PCH)-DPW
- Other Public Funded Entity (Licensed or Unlicensed) - Document Details in Notes
- Residential Treatment Facility
- State Mental Hospital-DPW

3. Type of abuse reported

- Sexual abuse
- Serious bodily injury (risk of death, permanent disfigurement, loss/impairment)
- Serious physical injury (causes severe pain, impairs physical functioning)
- Suspicious death
- Abuse not listed above-Document Details in Notes

3.C. MANDATORY REPORTS (Sexual Abuse, Serious Physical Injury, Serious Bodily Injury or Suspicious Death)

1. Was the mandatory reporter advised of additional reporting requirements to the appropriate State Agency and Law Enforcement?

- Yes
- No (Not one of the four serious, skip to 3.C.4)

2. Date the PS Agency reminded the organization/facility of the additional reporting requirements to the appropriate State Agency and Law Enforcement (MM/DD/YYYY)

____/____/____

3. Time the PS Agency reminded the organization/facility of the additional reporting requirements to the appropriate State Agency and Law Enforcement (include AM or PM)

4. When was the mandatory written report from the facility received by the appropriate PS Agency/Entity?

- Within 48 hours
- More than 48 hours
- Not received

5. Did the PS Agency forward the facility's mandatory written report to the appropriate State Agency?

- Yes
- No

4. REPORT OF NEED SUMMARY

4.A. REPORT OF NEED SUMMARY

1. What is the Category assigned to the Report of Need at intake?

- Emergency-Immediately refer to PS
- Priority-Immediately refer to PS
- Non-priority-Normal Business
- No need for PS (complete 4.A.2)
- Referred to another entity-include date/time and person receiving RON in Notes.

2. Why categorized as No Need for Protective Services? Document Details in Notes

- Is not in the jurisdiction of PA (OAPSA only)
- Is not a resident of PA (APS only)
- Under age 60 (OAPSA only)
- Under age 18 or over age 59 (APS only)
- Able to perform or obtain services on their own (OAPSA only)

- Able to obtain PS without the assistance of another person (APS)
- No imminent risk to person or property (OAPSA or APS)
- Has a responsible caretaker (OAPSA only)
- No physical/mental impairment limiting 1 or more major life activity (APS only)

4.B. RON CONFIRMATION (Completed by PS Worker or Supervisor)

1. Date Report of Need was received by Protective Service Worker (MM/DD/YYYY)

____/____/____

2. Time Report of Need was received by Protective Service Worker (include AM or PM)

3. Was the Intake Report of Need Category confirmed? Document who confirmed or changed the category in Notes.

- No
- Yes-Skip to 4.B.5

4. If the Category assigned at intake to this Report of Need was changed, enter the appropriate Category here.

- Emergency-Immediately refer to PS
- Priority-Immediately refer to PS
- Non-Priority-Normal Business
- No need for PS-Explain in Notes
- Referred to another entity

5. Based on review of the RON, what organizations/agencies were notified of the RON? Check all that apply. Document in the Notes the dates and individual names contacted for each choice below.

- Coroner

- Department of Aging (PDA)
- Department of Health (DOH)
- Department of Public Welfare (DPW)
- Law Enforcement - At time of RON - (i.e. NN due to consumer death)
- MH/DD
- Ombudsman
- Other-Document Details in Notes
- None-Document Details in Notes

6. If referred to a different entity, document the entity, county name, and name of individual receiving report.

5. SIGNATURES

5.A. SIGNATURES, TITLES, & DATES FOR REPORT OF NEED

1. Signature & Title of Intake Worker

2. Date Intake Worker Completed RON (MM/DD/YYYY)

____/____/____

3. Signature & Title of Caseworker Reviewing and/or Investigating

4. Date Caseworker and/or Investigator Received the RON (MM/DD/YYYY)

____/____/____

5. Signature & Title of Supervisor

6. Date Supervisor Reviewed and Approved the Receipt of the RON (MM/DD/YYYY)

____/____/____

7. Signature and Title of Director

8. Date Director Reviewed and Approved the Receipt of the RON and Assignment (MM/DD/YYYY)

____/____/____

Title : _____

_____ Date

Title : _____

_____ Date

Protective Services

Report of Need (RON) Instructions

The *Report of Need* (RON) form is to be completed when an allegation of abuse, neglect, exploitation, or abandonment is received or a referral is made to an Area Agency on Aging (AAA). The RON form can be completed either in SAMS or Mobile Assessments. If the RON form is completed in Mobile Assessments, the user will need to utilize the proper SAMS procedures to upload the form into SAMS. If the Consumer is not in SAMS, the Consumer must be registered in the system before completing the RON form. Please follow the SAMS Documentation User Manual for instructions on registering a consumer in SAMS and how to open a RON assessment form.

All questions on the RON form must be completed unless a SAMS automated/built-in skip pattern is activated during entry. In addition, questions marked as optional are at the discretion of the intake worker for completion and questions designated as “under 60 only” do not need to be completed for over 60 reports of need. All appropriate check boxes should be marked and supporting information for the selection is to be recorded in the Notes section. If a question is not applicable or information is not known, please utilize the appropriate check box for that question. Care should be taken to assure that all information documented on the RON form is accurate. *ALL Information used to complete the RON form must come from the reporter.* Additional calls to gather statistical data only (i.e. telephone numbers, addresses) are permissible. Calls made to gather any other information to evaluate risk are not permissible as this constitutes the start of an investigation. (APD #93-12-02/#93-24-02)

The worker completing the RON form should not expect the reporter to understand or have a working knowledge of protective services. Therefore, it is imperative that the worker completing the RON form ask probing questions to determine what the reporter is actually alleging, the presence or absence of risk, and to gather additional information included in the RON form. It is essential that the worker completing the RON form accurately record information so that the need for protective services and the categorization of the report can be accurately evaluated. The “None” and “Unknown” responses are only for when the reporter provides the response as “None” or “Unknown”. “Unknown” signifies that the reporter is unable to report on this specific risk, but the risk could potentially still be present. “None” signifies that no risk or concern has been reported by the reporter for the related question.

Additionally, it is critical for all staff to ensure that when they are logging into SAMS or Mobile Assessments, they use their individually assigned user ID and password. This is imperative because SAMS/Mobile Assessments will use the name/ID of the user signed on to the computer to record an electronic signature for the person completing the PS work. Never share user IDs or passwords. If using someone else’s computer, you must log into SAMS/Mobile Assessments with your user ID and password for the computer to recognize that you are completing the work. If you do not log on under your user ID, the computer will assign the electronic signature of the person signed onto SAMS/Mobile Assessments for the work that you have completed.

Instructions for RON Form Completion

1. REPORTER'S DETAILS

1.A. CONSUMER'S INFORMATION

Question 1: Date RON Received

Using the MM/DD/YYYY format, document the date that the RON was received.

Question 2: Time RON Received

Document the time of day that the RON was received. Include "AM" or "PM." Do not use military time.

Question 3: Date(s) of the Incident(s)

Document the date or dates of the alleged incident(s). If the exact date(s) is/are unknown, document the information that is provided by the reporter regarding the date(s) of the incidents(s) in the Notes section (i.e. "it happened three weeks ago" or "it happened about six months ago" or "I don't know when it happened" or "it is ongoing").

Question 4: LAST Name

Document the consumer's last name. Do not use nicknames.

Question 5: FIRST Name

Document the consumer's first name. Do not use nicknames. If the consumer goes by another name, document it in the Notes section.

Question 6: MIDDLE Initial

Document the consumer's middle initial.

Question 7: Name SUFFIX (if applicable)

Document the consumer's name suffix (i.e. Sr., Jr., III,) if applicable.

1.B. CONSUMER'S DEMOGRAPHIC DATA

Question 1: What type of communication assistance will be needed to communicate with consumer?

Document any information the reporter provided that indicates or suggests that communication assistance will/may be required when contacting and communicating with the consumer.

Question 2: Primary Language

Document the primary language understood and spoken by the consumer, if listed. If the primary language understood and spoken by the consumer is not listed, check the "other" box and document the language in the Notes section. Choose only one response.

Question 3: Date of Birth (DOB) (if unknown, document an indicated age range in Next Question, if DOB entered here, skip Question 1B4).

Using the MM/DD/YYYY format, document the consumer's date of birth. If the age is unknown, document indicated age range in question 1.B.4.

NOTE: If the answer to this question is known, skip Question 1.B.4.

Question 4: If DOB is unknown, indicate the consumer's age range.

If date of birth was unknown in question 1.B.3, document whether consumer is reported to be 60 years or older or under 60 in this question. Skip this question if the DOB is known and question 1.B.3 is answered.

Question 5: Consumer's Marital Status

Document the consumer's marital status as described by the reporter. Choose only one response.

Question 6: Gender

Document if the consumer is female or male.

Question 7: Social Security Number (SSN) (Optional)

Document the consumer's social security number, if known.

Question 8: Ethnicity

Document the consumer's ethnicity as described by the reporter. Choose only one response.

Question 9: Race(s)

Document the consumer's race as described by the reporter. Choose as many responses that are necessary.

Question 10: Current Living Arrangement (Include in the "Lives Alone" category, consumers who live in AL, Dom Care, and PCH, pay rent or have no roommate.)

Document the consumer's current living arrangement. The purpose of this question is to determine if the consumer lives alone or with other people.

- **Lives Alone:** Select this response if the consumer lives alone. Also select this response if the person lives in a personal care home, assisted living, domiciliary care home, group home, pays rent, or has no roommate.
- **Lives with Spouse Only:** Select this response if the consumer lives with his/her spouse. This response should be chosen regardless of whether anyone else also resides with the consumer and his/her spouse (i.e. the consumer lives with spouse along with any other individuals residing in the home).
- **Lives with Child(ren) but not Spouse:** Select this response when the consumer lives with a child, but there is no consumer spouse within the residence.
- **Lives with Other Family Members(s):** Select this response when the consumer lives with another family member (not spouse or child).
- **Other-Document Details in Notes:** Select this response when the consumer lives with another person (not spouse, child, or another family member) or resides in a nursing facility or other "institutional setting." Document the specifics regarding the consumer's living arrangements in the Notes section (i.e. where consumer resides/who consumer resides with).
- **Don't Know:** Select this response when the reporter does not know the living arrangements of the consumer.

NOTE: The Notes section should always be used to record any other detailed information or specifics regarding the consumer's living arrangement.

Question 11: CONSUMER'S Type of Residence at Time of Reported Event

Using the available check boxes, document the consumer's place of residence at the time that the RON was taken. If the selections available do not list the consumer's residence, use the

“Other-Document Details in Notes” selection and ensure the Notes section is used to explain the specific residence information. If the reporter does not know the consumer’s residence at the time of the reported event, select “unknown”.

Question 12: Identify where the incident occurred. If County is different than residence, document details in Notes.

Document where the consumer was located when the incident occurred. Use the Notes section to document the county where the incident occurred.

1.C. CONSUMER’S RESIDENTIAL ADDRESS INFORMATION

Question 1: Name of Facility if residing in a facility.

Document the facility name where the consumer is residing. If consumer is not in a facility, document as “N/A”.

Question 2: RESIDENTIAL Street Address (include number of house, apartment, or room).

Document the consumer’s residential street address (where the consumer actually resides), including house, apartment or room numbers.

Question 3: RESIDENTIAL Street Address Second Line (if needed)

Document additional residential street information that is not captured in question 1.C.2.

Question 4: Residential City or Town (Optional/must be located within the Residential Municipality)

Document the city or town in which the consumer resides.

Question 5: RESIDENTIAL Municipality – REQUIRED (Usually a township or borough where consumer votes, pays taxes)

Document the consumer’s municipality (the city, borough, town or township where the consumer pays his/her taxes – which frequently is not the same as the name of the town/city where the consumer resides).

Question 6: RESIDENTIAL County – REQUIRED

Document the county in which the consumer resides.

Question 7: CONSUMER'S Primary Telephone Number:

Document the telephone number where the consumer can be most readily reached. This may be a home or cellular telephone number.

Question 8: DIRECTIONS to Consumer's Location (Optional)

Document the directions that the worker would utilize to travel to the consumer's home/location.

Question 9: NAME of Emergency Contact

Document the name of the person identified as the consumer's emergency contact. If unknown, document "unknown" in the designated area.

Question 10: PHONE Number of Emergency Contact

Document the phone number of the person identified as the consumer's emergency contact. If unknown, document "unknown" in the designated area.

Question 11: NAME of Primary Care Physician

Document the full name of the consumer's primary care physician. If unknown, document "unknown" in the designated area.

Question 12: Business PHONE Number for Primary Care Physician

Document the business phone number for the consumer's primary care physician. If unknown, document "unknown" in the designated area.

1.D. CONSUMER'S POSTAL/MAILING ADDRESS INFORMATION

Question 1: POSTAL Street Address (Include number of PO Box, street, house, apartment or room)

Document the consumer's postal street address, including post office box, street, house, apartment or room numbers. The postal address is where the consumer's US mail is delivered.

Question 2: POSTAL Address Second Line (if needed)

Document additional postal address information that is not captured in question 1.D.1.

Question 3: POSTAL City or Town

Document the city or town in which the consumer's US mail is delivered.

Question 4: POSTAL State

Document the postal state in which the consumer's US mail is delivered.

Question 5: POSTAL Zip Code

Document the postal zip code in which the consumer's US mail is delivered.

2. REPORTER'S OBSERVATIONS

2.A. CONSUMER'S CURRENT SITUATION

Question 1: Identify ALL ALLEGATIONS made by the reporter. Document ALL Details provided regarding EACH ALLEGATION in the Notes section.

Check the corresponding response for the type of abuse that is/are alleged by the reporter. After checking the appropriate response(s), use the Notes section to describe, in detail, what the reporter alleges. Use care to fill out this section thoroughly as it is often the primary source of information used to categorize the *Report of Need*. If possible, use quotes from the reporter. Checking the response(s) that indicate the type of abuse is **NOT** sufficient for the completion of this question. Detailed information must be included that validates what type of abuse is being alleged.

Question 2: Is the Consumer in a Life Threatening Situation?

If the reporter does not know or the reporter's answer is contradicted by other information stated by the reporter, document this discrepancy in the Notes section.

Question 3: Reported physical and health conditions of consumer – Document ALL Details in Notes.

Check all responses that the reporter uses to describe the consumer's physical and/or health conditions. After checking all appropriate responses, describe in the Notes section all supporting documentation/information supplied by the reporter regarding each response that has been checked in the Notes section. If there are no reported physical and/or health conditions or the reporter specifically provides that there are no physical and/or health

conditions, check the box designated as “none/not reported”. If the reporter indicates they are uncertain of any physical and/or health conditions, check the box designated as “unknown”.

Question 4: Type of disability(ies) reported:

Check all responses that the reporter uses to describe the consumer’s disability(ies). After checking all appropriate responses, describe all supporting documentation/information supplied by the reporter regarding each response that has been checked in the Notes section. If there are no reported disabilities or the reporter specifically provides that there are no disabilities, check the box designated as “none/not reported”. If the reporter indicates they are uncertain of any disabilities, check the box designated as “unknown”.

Question 5: Indicate the types of substance abuse

Check all responses that the reporter uses to describe any substance abuse the consumer engages in or is occurring in the residence. After checking all appropriate responses, describe all supporting documentation/information supplied by the reporter regarding each response that has been checked in the Notes section. If there is no reported substance abuse or the reporter specifically provides that there is no substance abuse, check the box designated as “none/not reported”. If the reporter indicates they are uncertain of any substance abuse, check the box designated as “unknown”.

Question 6: Reported emotional and mental conditions of Consumer – Document all Details in Notes.

Check all responses that the reporter uses to describe the consumer’s emotional and/or mental condition. After checking all appropriate responses, describe all supporting documentation/information supplied by the reporter regarding each response that has been checked in the Notes section. If the Consumer has been formally diagnosed with an emotional or mental condition, document this in the Notes section. If the Consumer has been declared incapacitated by a court through a guardianship hearing, document this in the Notes section. If there are no reported emotional and/or mental conditions or the reporter specifically provides that there are no emotional and/or mental conditions, check the box designated as “none/not reported”. If the reporter indicates they are uncertain of any emotional and/or mental conditions, check the box designated as “unknown”.

Question 7: Reported problems with the physical environment of Consumer – Document all Details in Notes

Check all responses that the reporter uses to describe the Consumer’s physical environment. After checking all appropriate responses, describe all supporting documentation/information supplied by the reporter regarding each response that has been checked in the Notes section. If there are no reported issues with the physical environment or the reporter specifically provides that there are no concerns with the physical environment, check the box designated as “none/not reported”. If the reporter indicates they are uncertain of any issues, check the box designated as “unknown”.

Question 8: Note any dangers – Document Details in Notes.

Check all responses that the reporter uses to describe any dangers in and/or around the consumer's environment. After checking all appropriate responses, describe all supporting documentation/information supplied by the reporter regarding each response that has been checked in the Notes section. If there are no reported dangers or the reporter specifically provides that there are no dangers, check the box designated as "none/not reported". If the reporter indicates they are uncertain of any dangers, check the box designated as "unknown".

Question 9: Reported financial problems of Consumer – Document Details in Notes.

Check all responses that the reporter uses to describe reported financial problems. After checking all appropriate responses, describe all supporting documentation/information supplied by the reporter regarding each response that has been checked in the Notes section. If there are no reported financial problems or the reporter specifically provides that there are no financial problems, check the box designated as "none/not reported". If the reporter indicates they are uncertain of any financial problems, check the box designated as "unknown".

Question 10: Does the Consumer have assistance with legal/financial concerns?

Choose the appropriate response. If response is "No", skip to 2.A.12. If the reporter indicates that they are uncertain of any assistance with legal/financial concerns, indicate "unknown".

Question 11: If response to 2.A.10 is "Yes", check all appropriate options from the list below.

If "Yes" was chosen in 2.A.10, check all appropriate responses. Document any specific information or identifiers of the person/entity reported to be providing legal/financial assistance in the Notes section.

Question 12: What is the name of the Alleged Perpetrator? (Document if N/A or unknown)

If the reporter can identify an alleged perpetrator, document this information in the Notes section. Include the name(s) of the alleged perpetrator(s), contact information, location, etc., along with any characteristics of the individual(s). If there is no alleged perpetrator reported or the reporter specifically indicates that there is no alleged perpetrator, indicate "N/A". If the reporter indicates they are uncertain of any alleged perpetrator, indicate "unknown".

Question 13: Does the Alleged Perpetrator currently have access to the Consumer/Consumer assets?

Choose the response that is most appropriate given the information supplied by the reporter. Document all applicable details in the Notes section. If “Possible” or “N/A,” select “unknown” and document details in the Notes section.

Question 14: Where is the Consumer currently located?

Document where the consumer is physically located at the time of the report (i.e. home, hospital, NF, homeless).

3. REPORTER’S DATA

3.A. REPORTER’S INFORMATION

Question 1: REPORTER’S First and Last Name

Document the reporter’s first and last name. If reporter chooses to remain anonymous, document “anonymous.” Mandatory reporters CANNOT be anonymous.

Question 2: REPORTER’S Phone Number

Document the reporter’s telephone number, including the area code. If the reporter is from an organization or facility, the telephone number should be the telephone number of the organization/facility. If the reporter is not from an organization or facility, the number should be the telephone number where the reporter can most readily be reached.

Question 3: Is this a MANDATED Report?

Check appropriate response. If “yes”, skip to 3.B.

Question 4: Type of VOLUNTARY Reporter

Given the information supplied by the reporter, choose the response that is most appropriate. After voluntary reporter selection type is completed, skip to section 4. If this is a MANDATORY report, do not complete this question, skip to section 3.B.

3.B. MANDATORY REPORTERS (If report is voluntary, skip to 4.A)

Question 1: NAME of the Organization/Facility – Mandatory Facilities CANNOT be Anonymous.

Document the name of the organization/facility the reporter is calling from.

Question 2: Type of MANDATORY Reporter

Given the information supplied by the reporter, choose the response that is most appropriate. Choose only one response.

Question 3: Type of abuse reported

Given the information supplied by the reporter, choose the response that is most appropriate. If the abuse does not involve sexual abuse, serious physical injury, serious bodily injury, or suspicious death, check “abuse not listed above” and document the details of the abuse type in the Notes section.

3.C. MANDATORY REPORTS (Sexual Abuse, Serious Physical Injury, Serious Bodily Injury, or Suspicious Death)

Question 1: Was the mandatory reporter advised of additional reporting requirements to the appropriate State Agency and Law Enforcement?

Select the appropriate response. Additional reporting requirements are required of the reporter for reports involving sexual abuse, serious physical injury, serious bodily injury, or suspicious death. The intake/PS worker is required to advise the reporter of additional reporting requirements to the appropriate state agencies and law enforcement. If the answer is no, skip to 3.C.4.

NOTE: If question 3.B.3’s response was “abuse not listed above”, the answer to this question should be No.

Question 2: Date the PS Agency reminded the organization/facility of the additional reporting requirements to the appropriate State Agency and Law Enforcement:

Using the MM/DD/YYYY format, document the date that the organization/facility was notified of the additional reporting requirements to appropriate state agencies and law enforcement.

Question 3: Time the PS Agency reminded the organization/facility of the additional reporting requirements to the Appropriate State Agency and Law Enforcement

Document the time, including “AM” or “PM” that the organization/facility was notified of the additional reporting requirements to appropriate state agencies and law enforcement.

Question 4: When was the mandatory written report from the facility received by the appropriate PS Agency/Entity?

Select the appropriate response of when the PS agency received the written report from the facility in relation to when the PS agency received the oral report from the facility.

Question 5: Did the PS Agency forward the facility’s mandatory written report to the appropriate State Agency?

Select YES if the report involved one of the four serious (sexual abuse, serious physical injury, serious bodily injury, or suspicious death). Use the Notes section to document when, how, and to who was the report provided.

Select NO if the report did not involve one of the four serious (sexual abuse, serious physical injury, serious bodily injury, or suspicious death) or the PS agency never received the written report from the facility. Use the Notes section to designate the reason for the selection of no.

4. REPORT OF NEED SUMMARY

4.A. REPORT OF NEED SUMMARY

Question 1: What is the Category assigned to the Report of Need at intake?

Choose the appropriate category for this RON in accordance with the appropriate statute/regulations (Older Adults Protective Services Act or Adult Protective Services). Choose only one category. This categorization must be based solely on the information provided by the reporter and which has been documented in the RON.

If categorized as No Need for PS, proceed to question 4.A.2; otherwise skip to section 4.B.

If the RON is being referred to another entity, use the Notes section to document who the report was referred to along with the date and time of the referral.

For RONs being referred to Adult Protective Services entity, categorize as “No Need for PS”.

Question 2: Why categorized as No Need for Protective Services? Document Details in Notes

If the *Report of Need* was categorized as No Need for PS, select the appropriate reason(s) for this selection. The Notes section must be used to provide supporting documentation to justify each selection made.

4.B. RON CONFIRMATION (Completed by PS Worker or Supervisor)

Question 1: Date Report of Need was received by Protective Service Worker

Using the MM/DD/YYYY format, document the date this RON was received by the Protective Services Worker or Supervisor for confirming the report categorization. Use the Notes section to identify the name/title (worker or supervisor) of the individual completing the confirmation.

Note: If this RON is a referral from another entity, the investigating agency can also utilize this response area to document the date and name of person receiving the referred RON. Please ensure the investigating entity is documenting that their signature identifies the receipt of transfer.

Question 2: Time Report of Need was received by the Protective Service Worker

Document the time, including "AM" or "PM" that this RON was received by the PS worker or supervisor for confirming the report categorization. Use the Notes section to identify the name/title (worker or supervisor) of the individual completing the confirmation.

Note: If this RON is a referral from another entity, the investigating agency can also utilize this response area to document the time and name of person receiving the referred RON. Please ensure the investigating entity is documenting that their signature identifies the receipt of transfer.

Question 3: Was the Intake Report of Need Category confirmed? Document who confirmed or changed the category in Notes.

This question needs to be answered immediately after intake to ensure the proper categorization.

Document whether the initial category assigned to the RON was confirmed. If the PS worker or supervisor agrees with the categorization, select "Yes" and skip to question 4.B.5.

If "No", proceed to question 4.B.4 and answer appropriately.

Question 4: If the Category assigned at intake to this Report of Need was changed, enter the appropriate Category here.

This question is to be skipped if question 4.B.3. was answered "Yes".

If question 4.B.3. was answered “No”, select the appropriate categorization and document the correct/new category assigned to the RON. Choose only one category.

Note: If this RON is a referral from another entity, the investigating agency can also utilize this response area to document. Please ensure the investigating entity is documenting their signature after entering information.

Question 5: Based on review of the RON, what organization/agencies were notified of the RON? Check all that apply. Document in the Notes the dates and individual names contacted for each choice below.

Select all appropriate entities contacted and document individual names contacted for each selection in the Notes section.

Note: If this RON is a referral from another entity, the investigating agency can also utilize this response area to document. Please ensure the investigating entity is documenting their signature after entering information.

Question 6: If referred to a different entity, document the entity, County name, and name of individual receiving report.

If 4.A.1 is selected “referred to another entity” or the RON is being referred to the Adult Protective Services entity, the agency that took the report should document the entity name, county name, person from investigative entity receiving the report, along with the date and time the RON was referred to the investigative entity.

5. SIGNATURES

5.A. SIGNATURES, TITLES AND DATES FOR REPORT OF NEED

Each person completing and/or reviewing any section of this RON must document their name, title, and date in this area.

Question 1: Signature & Title of Intake Worker

The person completing the initial RON shall be designated as the intake worker and is required to use this section to record their name and title.

Question 2: Date Intake Worker Completed RON

The person completing the initial RON shall document the date the intake was completed using the MM/DD/YYYY format.

Question 3: Signature & Title of Caseworker Reviewing and/or Investigating

The person assigned the RON for review and/or investigation should document their name and title in this section.

NOTE: If this RON is a referral from another entity, the investigative entity/investigator can also utilize this response area to document their name and title. Please ensure the investigative entity is documenting that their signature identifies the transfer.

Question 4: Date Caseworker and/or Investigator Received the RON

The person assigned the RON for review and/or investigation shall document the date they received the RON for investigation using the MM/DD/YYYY format.

NOTE: If this RON is a referral from another entity, the investigative entity/investigator can also utilize this response area to document the date they received the RON. Please ensure the investigating is documenting that their signature identifies the transfer.

Question 5: Signature and Title of Supervisor

The person designated as the supervisor of the intake and/or caseworker shall document their name and title in this section.

NOTE: If this RON is a referral from another entity, the investigative entity/supervisor can also utilize this response area to document their name and title. Please ensure the investigating entity is documenting that their signature identifies the transfer.

Question 6: Date Supervisor Reviewed and Approved the Receipt of the RON

The supervisor shall document the date they reviewed and approved the completion and/or assignment of the RON using the MM/DD/YYYY format.

NOTE: If this RON is a referral from another entity, the investigative entity/supervisor can also utilize this response area to document the date they received the RON. Please ensure the receiving entity is documenting that their signature identifies the transfer.

Question 7: Signature and Title of Director

If the Director is required to sign off on the intake of a RON, this question shall be used for the Director to record their name and title.

NOTE: If this RON is a referral from another entity, the investigative entity/Director can also utilize this response area to document their name and title. Please ensure the receiving entity is documenting that their signature identifies the transfer.

Question 8: Date Director Reviewed and Approved the Receipt of the RON and Assignment

If the Director is required to sign off on the intake of a RON, this question shall be used for the Director to record the date they reviewed and approved the receipt of the RON along with the caseworker/investigator assignment using the MM/DD/YYYY format.

NOTE: If this RON is a referral from another entity, the investigative entity/Director can also utilize this response area to document the date they received the RON. Please ensure the receiving entity is documenting that their signature identifies the transfer.

ASSESSMENT NARRATIVE:

PDA does not require information to be placed in this field. Any information placed in this field must also appear in the PS care plan journals if the case is being investigated.

Agencies may use this area at their discretion, as per agency policy. Use of this field must be consistent throughout the agency and in accordance with agency policy.

Information recorded in this area cannot contain any information obtained from other assessment forms or personal information a worker may have or know regarding the consumer. Information recorded in this section should only be supplemental information provided by the reporter. This area can also be used to further document the receipt and routing of the RON.