# Office of Attorney General Referral Form – Department of Aging, Protective Services Office

| Referral Source | | | |
|---|---|---|---|
| **Complainant:** | Department of Aging<br>555 Walnut Street<br>Harrisburg, PA 17101 | | |
| **PDA (AAA)**<br>**Contact Person(s):**<br>▪ **Names**<br>▪ **Titles**<br>▪ **Telephone**<br>▪ **Email** | | | |
| **Victim Information** | | | |
| **First Name:** | | **Last Name:** | |
| **Social Security Number:** | | **Gender:** | ☐ Male ☐ Other<br>☐ Female |
| **Date of Birth:** | | **Age at Time of Event:** | |
| **Location of Residence:** | ☐ Adult Training Facility (2380)<br>☐ Assisted Living Facility (2800)<br>☐ Birth Centers (501)<br>☐ Caretaker's home<br>☐ Community Homes for Individuals w/ ID (6400)<br>☐ CRR-Mental Health (5310)<br>☐ Domiciliary Care Home (21)<br>☐ Family's Home<br>☐ Friend's Home<br>☐ Family Living/Shared Living (6500)<br>☐ Hospital LTC<br>☐ ICF/ID (6600) | | ☐ LTSR/MH (5320)<br>☐ Inpatient Psych Facility<br>☐ Nursing Home (210)<br>☐ OA Daily Living Center (11)<br>☐ Own Home/Apartment<br>☐ Personal Care Home (2600)<br>☐ Residential Treatment Fac. For Adults (5100)<br>☐ State Mental Hospital (5100)<br>☐ Vocational Facilities (2390)<br>☐ Other (Specify): |
| **Address:** | | **Residential County:** | |
| **Special Communication Needs:** | ☐ None<br>☐ Nonverbal<br>☐ Deaf / Hearing Impaired | | ☐ Primary Language not English<br>☐ Other (Specify): |
| **Disability/Impairment** | ☐ Physical<br>☐ Cognitive | Diagnoses (List): | |
| **Perpetrator Information** | | | |
| | | | |
| | ☐ Family Member Compensated for Services<br>☐ Friend Compensated for Services<br>☐ Provider Employee | | ☐ Other (Specify): |

Confidential: The contents of this document are internal pre-decisional records of the PDA. Individuals receiving and reviewing this document must not provide this information to any other person without written permission. 65 P.S. § 67.708 (b) (10). Furthermore, the information transmitted is intended only for the person or entity to whom it is addressed and may contain confidential and/or privileged material. Any use of this information other than by the intended recipient is prohibited. Unintended transmissions shall not constitute waiver of the attorney-client or any other privilege.

| Complete the section below if the perpetrator was the owner, operator, manager or employee of a nursing home, domiciliary care home, adult daily living center, community residential facility, any health care facility under §802.1 of Health Care Facilities Act, or provider that renders home health services. | | |
|---|---|---|
| **Provider Agency:** | | |
| **License Number:** | | |
| **Provider Business Address, if Different from Individual's Address:** | | |
| **Provider Telephone:** | | |
| **Chief Executive Officer:** | | |
| **Event Information** | | |
| **Referral Type: (Check One)** | ☐ Abuse (§2713.1) | ☐ Neglect (§2713) |
| **Event Description: (Check all that Apply)** | ☐ Impairment of physical Condition<br>☐ Substantial pain<br>☐ Bodily injury which resulted in death<br>☐ Bodily injury which creates a substantial risk of death | ☐ Bodily injury which causes serious, permanent disfigurement or protracted loss or impairment of the function of any bodily member or organ<br>☐ Unlawful restraint<br>☐ Abuse as defined at § 2713.1(a) |
| **Description of Event:** | | |
| **Attachments (list here):** | | |

Email completed form to: bcowher@attorneygeneral.gov and your assigned PDA specialists