NEIL ABERCROMBIE
GOVERNOR

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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Child Welfare Services Intake Unit
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CONFIDENTIAL

MANDATED REPORTER CHECKLIST FOR SUSPECTED CHILD ABUSE AND NEGLECT

Oahu Reporting Line: (808) 832-5300 Toll Free Neighbor Islands: 1-800-494-3991
Oahu FAX: (808) 832-5292 Toll Free Neighbor Islands FAX: 1-800-399-1614

To file a report of Child Abuse and Neglect, please:

1. Review available records and fill out the checklist as completely as possible using **Y** for yes, **N** for no, or as specified. Leave blank if unknown, unless otherwise indicated.
2. Immediately call the **CWS Intake Reporting Line at (808) 832-5300 or toll free for neighbor islands at 1-800-494-3991** to report your findings. Be sure to obtain the name of the intake social worker to document receipt and disposition of your referral.
3. FAX or Mail this document with comments to CWS immediately **after** verbally reporting to the intake worker. **Doing so fulfills your statutory obligation under Chapter 350-1.1(c), Hawaii Revised Statutes, which requires a report in writing as well as the oral report.**

MANDATED REPORTER INFORMATION	
Name/Agency/Title:	
Address:	Telephone:

MANDATED REPORTER ORAL REPORT/CONTACT WITH CWS AND/OR POLICE	
Name of CWS Intake Social Worker	Date/Time of Report
Name of Police Officer/Badge #	Date/Time of Report/Police Report #
May CWS share your identity with the county police, or contract VCM or FSS provider for follow up? Yes ___ No___	

PARENT/CAREGIVER INFORMATION: (Circle where applicable)							
FATHER	GUARDIAN	OTHER	ALLEGED MALTREATOR	MOTHER	GUARDIAN	OTHER	ALLEGED MALTREATOR
Name:			DOB/Age	Name:			DOB/Age
Address or Directions:				Address or Directions:			
Employment/Phone				Employment/Phone			
Telephone:		Military/Branch of Service		Telephone:		Military/Branch of Service	

OTHER ALLEGED MALTREATER/S			
Name:	DOB/Age	Name:	DOB/Age
Address or Directions:		Address or Directions:	
Telephone:		Telephone:	
Relationship to victim:		Relationship to victim:	

OTHER FAMILY/HOUSEHOLD MEMBERS/SIGNIFICANT KIN		
Name	DOB/Age	Relationship to Victim
1.		
2.		
3.		
4.		

CHILD/VICTIM INFORMATION				
Name	DOB/ Age	Victim? Y/N	School/Grade/SPED	Home Address/or Directions
1.				
2.				
3.				
4.				

FACTORS

A. TYPE OF HARM:

	Physical abuse		Threatened physical abuse
	Sexual abuse		Threatened sexual abuse
	Physical neglect		Threatened physical neglect
	Psychological/emotional abuse		Threatened psychological harm

B. EVIDENCE OF HARM:

a		Substantial/multiple skin bruising/Internal Bleeding	j		Extreme pain
b		Injury causing substantial bleeding	k		Extreme mental distress
c		Malnutrition	l		Gross degradation (extreme humiliation)
d		Failure to thrive	M		Death
e		Burns	n		Physical or medical evidence of sexual abuse
f		Poisoning	o		Injury to the psychological capacity/impairment in child's functioning
g		Any fracture	p		Failure to provide adequate care or supervision
h		Subdural hematoma (per medical diagnosis)	q		Intentional Drugging
i		Soft tissue swelling	r		Other:

C. HISTORY, FREQUENCY, DURATION, INTENSITY OF HARM, if known by reporter:

	Single incident, no history, no previous incidents		Occurs repeatedly,several times/year, escalating
	Infrequent incidents, no escalation , short duration		Chronic and serious, ongoing pattern of harm

D. BEHAVIORAL: (Has the **child** demonstrated any of the following behaviors?)

a		Danger to others:Assaults/aggression	e		Status Offenses or Law Violation
b		Danger to self/self destructive/suicidal	f		Education/Academic Difficulties
c		Mental Health Issues, Withdrawal or depression	g		Fear of caretaker/returning home/being harmed again
d		Inappropriate sexual knowledge/seductive	i		Other: Specify

E. SERVICES/TREATMENT HISTORY:

Has the family participated or been offered/referred to any service or treatment prior to the report of harm such as: (Yes, **N**o, **U**nknown, or **D**eclined, **I**dentified as a need**) If known, identify service provider and contact information.**

a		Parenting classes	g		Medical/Health Services
b		Family violence services (domestic/family abuse)	h		Public Health Nursing
c		Educational programs	i		Substance abuse counseling/treatment Inpatient__ Outpatient __
d		Individual counseling or therapy	j		Anger management
e		Intensive home based (outreach,home visit)	k		CWS involvement (Hawaii or other)
f		Mental Health /Psychiatric Services	l		Other, Specify:

F. SUPPORT SYSTEM:

Support system available to the child and family, willing and able to assist. If known, identify person(s) and contact information.

a		Parents	F		Friends
b		Maternal grandparents	G		Church members
c		Paternal grandparents	h		Community groups
d		Siblings	i		Service providers
e		Other relatives	j		Other: specify below

G. NARRATIVE INFORMATION:

Please provide a brief narrative description of the incident(s) and what action you believe needs to be taken. If known, include dates and location. (Use additional sheets as needed)

THANK YOU FOR YOUR ASSISTANCE.