State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Social Services Division
Adult Protective & Community Services Branch

CONFIDENTIAL

REPORT FORM FOR SUSPECTED ABUSE AND NEGLECT OF VULNERABLE ADULTS

In accordance with HRS §346-224, to file a report of abuse, neglect, and/or exploitation of vulnerable adults, please:

1. Review available records and fill this form as completely as possible. Please type or print legibly. Use **Y** for Yes, **N** for No, or as specified. If requested information is not known, use **U** for Unknown. If not applicable, use **N/A** for Not Applicable.
2. Immediately call the **Adult Protective Services (APS) Intake Reporting Line** in your county to report your findings. Refer to the last page of this form for contact information.
3. FAX, e-mail, or mail this form with comments to APS immediately **after** verbally reporting to the intake worker.

If you are a mandated reporter, submission of this form fulfills your statutory obligation under Hawaii Revised Statutes (HRS) §346-224 requiring a written report as well as an oral report.

REPORTER INFORMATION	
☐ **Check if you are a Mandated Reporter**	☐ **Check if anonymity is requested**
Name / Agency / Title (as applicable):	
Address:	Phone Number: Is this a direct number? ☐ Yes ☐ No
Relationship to alleged victim:	

TYPE OF HARM (check all that apply)		
☐ Physical Abuse	☐ Sexual Abuse	☐ Self Neglect
☐ Psychological Abuse	☐ Caregiver Neglect	☐ Financial Exploitation

Date of Incident:________________	Location: ☐ Home ☐ Care/Foster Home ☐ Nursing Facility ☐ Hospital ☐ Other:______ ____________

VULNERABLE ADULT INFORMATION		
Name (Last, First, M.I.)	Date of Birth:	Gender: ☐ Male ☐ Female
Home Address (Including apartment / unit number):	Phone Numbers (Home / Cellular / Other):	
Living Arrangement (i.e., Lives alone, with family, spouse, caregiver, etc.):		
Present Location (If different from above, i.e. care home, with other family, etc.):		
Ethnicity:	Primary Language Spoken, if known:	
Communicates verbally? ☐ Yes ☐ No ☐ Unknown	Interpreter needed? ☐ Yes ☐ No ☐ Unknown	
Disabilities seen (i.e., physical, medical, or behavioral conditions, vulnerability of the adult): ☐ Mobility impairment ☐ Hearing or vision impairment ☐ Frail or appears ill ☐ Medical condition ☐ Behavioral condition ☐ Other (specify):____________________________		

VULNERABLE ADULT INFORMATION (con't.)

Vulnerable adult's appearance and behavior:

☐ Alert, oriented ☐ Alert, but forgetful ☐ Nervous, anxious
☐ Incoherent, confused ☐ Unkempt, poorly groomed ☐ Other (specify):___________________________

Additional information (i.e. changes in behavior, changes in appearance, grooming, ability to care for self, etc.):

Other vulnerable adults at risk? ☐ Yes ☐ No **If yes, please attach additional pages as necessary:**

PRESENTING CONCERNS OF VULNERABLE ADULT

☐ Intellectual disability
☐ Mental health concerns
☐ Other (specify):______________

☐ Physical disability/Assistive device used:_________________________________
☐ Other mental health impairment (specify):______________________________

☐ Developmental disability
☐ Substance abuse
☐ Death

INDICATORS OF HARM:

☐ Decubitus ulcers (bedsores)
☐ Injury causing substantial bleeding
☐ Failure to provide adequate care
☐ Evidence of sexual abuse

☐ Substantial / multiple skin bruising
☐ Burns
☐ Extreme mental distress
☐ Other (specify):___________________

☐ Malnutrition
☐ Fractures / Broken bones
☐ Misuse of medications

Please describe in detail:

ALLEGED PERPETRATOR(S): List facility if applicable

☐ **Check if Self Neglect, go to page 3.**

Name (Last, First, M.I.) and nicknames, alias:

Age:

Gender: ☐ Male ☐ Female

Home Address (including apartment / unit number):

Phone Numbers (Home / Cellular / Other):

Work Address:

Relationship to the Vulnerable Adult:

☐ Caregiver ☐ Child ☐ Spouse ☐ Parent
☐ Sibling ☐ Family member (specify): ☐ Health Practitioner ☐ Financial Advisor
☐ Other (specify):___________ __________________________
____

Ethnicity:

Primary Language Spoken, if known:

Interpreter needed? ☐ Yes ☐ No ☐ Unknown

Does the alleged perpetrator still have access to the vulnerable adult?

Other perpetrators? ☐ Yes ☐ No **If yes, please attach additional pages as necessary:**

Do you think the vulnerable adult has decisional capacity? ☐ Yes ☐ No ☐ Unknown

(HRS §346-222 defines capacity as: the ability to understand and appreciate the nature and consequences of making decisions concerning one's person or to communicate these decisions.)

If no, why do you think the vulnerable adult lacks decisional capacity: ____

____

Is there any supporting documentation on decisional capacity? ☐ Yes ☐ No ☐ Unknown **If yes, please attach.**

SERVICES/TREATMENT HISTORY:

Check services or treatment the vulnerable adult or alleged perpetrator were offered prior to this report. Check all that apply. List service provider and contact information in space below.

☐ Medical / Health Services
☐ Domestic Violence/Abuse
☐ Behavioral Health Services
☐ Substance abuse counseling/treatment: ☐Inpatient ☐Outpatient
☐ Legal Services
☐ Case management services
☐ Public Health Nursing
☐ APS involvement (Hawaii or elsewhere)
☐ Financial Management / Services
☐ Other (specify):______________________________

Service provider(s) and contact information:

SUPPORT SYSTEM:

Support system available and willing to assist the vulnerable adult. List name(s) and contact information in the space below.

☐ Spouse
☐ Family Member(s)
☐ Community groups
☐ Parent(s)
☐ Friend(s)
☐ Other (specify):__________
____
☐ Child
☐ Church member(s)
☐ Sibling(s)
☐ Service providers

Name(s) and contact information:

NARRATIVE INFORMATION:

Describe the incident(s) and what action you believe needs to be taken. If known, include dates and location. List any health and/or environmental hazards or concerns. Use additional pages as necessary.

____

Signature of Reporter **Date**

THANK YOU FOR YOUR ASSISTANCE.

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
ADULT PROTECTIVE SERVICES

Business hours: 7:45 a.m. to 4:30 p.m., Monday to Friday (excluding holidays).
Phone calls, FAXES, and e-mails received after hours will be answered the next working day.

	Phone:	FAX:	E-mail:
Oahu:			
420 Waiakamilo Road, #202 Honolulu, HI 96817	832-5115	832-5391	SSDOahuAPCS@dhs.hawaii.gov
Kauai:			
4370 Kukui Grove Street, #203 Lihue, HI 96766	241-3337	241-3476	SSDKauaiAPCS@dhs.hawaii.gov
East Hawaii: (Hilo / Hamakua / Puna / Volcano)			
1055 Kino'ole Street, #201 Hilo, HI 96720	933-8820	933-8859	SSDEastHIAPCS@dhs.hawaii.gov
West Hawaii: (Kona / Kohala / Kamuela / Kau)			
75-5995 Kuakini Highway, #433 Kailua-Kona, HI 96740	327-6280	327-6292	SSDWestHIAPCS@dhs.hawaii.gov
Maui / Molokai / Lanai:			
1773-B Wili Pa Loop Wailuku, HI 96793	243-5151	243-5166	SSDMauiAPCS@dhs.hawaii.gov