State of Hawaii
Department of Human Services

Social Services Division
Adult Protective & Community
Services Branch

CONFIDENTIAL

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ADULT PROTECTIVE SERVICES (APS)
REPORT FORM FOR VULNERABLE ADULT ABUSE

To report abuse, neglect, and/or exploitation of vulnerable adults:

1. As soon as possible, call the **Statewide APS Reporting Line**: **832-5115**.
2. **Submit this form to Statewide APS Intake Unit as soon as possible, including after business hours.**
   Fax: (808) 832-5391 **E-mail:** SSDOahuAPCS@dhs.hawaii.gov **Mail:** 1010 Richards St., #710; Honolulu, HI 96813
3. **MANDATED REPORTERS: Hawaii Revised Statutes §346-224 requires you to submit a written report as well as an oral report.** Submission of this completed form meets the written report requirement.
4. **Complete this form thoroughly to the best of your knowledge. Attach available documents to support this report.** Example: Physician capacity assessments, or power of attorney or guardianship papers.
5. Complete **ONE form for EACH alleged victim**. Please type or print legibly.

County where incident occurred: ☐ **Honolulu** ☐ **Hawaii** ☐ **Maui** ☐ **Kauai**

☐ **Mandated Reporter**

REPORTER

☐ **Anonymity is requested**

Name (Last, First M.I.):				
Relationship to alleged victim:	☐ Offspring:	☐ Service Provider:	☐ Other:	
	☐ Other relative:	☐ Staff of Care Facility:		
Agency:		**Occupation / Title:**		
Address: (Street address, unit number)			**Phone Numbers:** (include extension when applicable)	
			Work:	Cell:
City	State	Zip Code / Island		Other:
			Fax:	
Alternate contact (Ex. If reporter is not available. Provide name, agency, position, phone number):				

ALLEGED VICTIM (AV)

Name: (Last, First, M.I., nicknames, alias, or description if unknown):	**Date of Birth / Age:**	**Gender:** ☐ Male ☐ Female ☐ Other	
Home Address: (Street address, unit number)		**Phone Numbers:**	
		Home:	Other:
City / State / Zip Code / Island		Cell:	

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Present Living Arrangement:

☐ Own Home	☐ Developmental Disabilities Home	☐ Nursing Facility
☐ Adult Residential Care Home (ARCH)	☐ Expanded ARCH	☐ Offspring Home
☐ Assisted Living Facility	☐ Homeless	☐ Other Relative Home
☐ Community Care Foster Family Home	☐ Hospital	☐ Other:

Please specify (Name of facility/home or person residing with. If homeless, describe the person, physical location, and/or vehicle):

Ethnicity:	**Primary language spoken, if known:**	**Interpreter needed?** ☐ Yes ☐ No ☐ Unknown

ALLEGED VICTIM (continued)

Type of vulnerability: ☐ Physical impairment ☐ Mental impairment ☐ Developmental impairment

Known diagnoses / conditions (alphabetical):

☐ Anxiety:	☐ COPD	☐ Diabetes	☐ Intellectual disability	☐ Schizophrenia
☐ Autism	☐ Dementia:	☐ Epilepsy	☐ Learning disability	☐ Stroke
☐ Bipolar D/O		☐ Hearing impaired	☐ Multiple sclerosis	☐ Substance Abuse
☐ Cancer:	☐ Depression	☐ Heart disease	☐ Muscular dystrophy	☐ Traumatic Brain Injury
☐ Cerebral palsy	☐ Developmental disability	☐ Heart failure	☐ Parkinson's	☐ Vision impaired

Please clarify, list other known diagnoses, list medication / treatments, OR attach medical records identifying diagnoses and medication / treatments:

Presenting concerns (alphabetical):

☐ 24-hour care	☐ Danger to others	☐ Frail / weak	☐ Other:
☐ Aggression	☐ Decision making	☐ Hallucinations	
☐ Bedbound	☐ Delusions	☐ Nonverbal	
☐ Danger to self	☐ Falls / fall risk	☐ Wandering	

Assistive devices:

☐ Cane	☐ Walker
☐ Hearing aid	☐ Wheelchair
☐ Scooter	☐ Other:

Capacity:

Hawaii Revised Statutes §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.

Does the alleged victim have decisional capacity? ☐ Yes ☐ No ☐ Questionable ☐ Unknown

Any documentation regarding decisional capacity? ☐ Yes ☐ No ☐ Unknown ***Please attach if available**

- Example: Capacity assessment or letter by an MD, or other documentation in a medical chart.
- If information is available regarding capacity, but you do not have the information, please identify who does.

Indicators: ☐ Alert, oriented ☐ Coherent ☐ Disoriented ☐ Incoherent ☐ Memory loss ☐ Confused

Please explain:

AV's Representatives: If other than Alleged Perpetrator (AP), provide name, relationship, contact. **Please attach available documents.**

☐ Guardian	☐ AP:	☐ Other:	☐ Attached
☐ Conservator	☐ AP:	☐ Other:	☐ Attached
☐ POA / DPOA	☐ AP:	☐ Other:	☐ Attached
☐ Trustee	☐ AP:	☐ Other:	☐ Attached
☐ Representative Payee	☐ AP:	☐ Other:	☐ Attached
☐ Veterans Affairs Fiduciary	☐ AP:	☐ Other:	☐ Attached
☐ Health Care Agent / Surrogate	☐ AP:	☐ Other:	☐ Attached

Other vulnerable adults at risk? ☐ Yes ☐ No **If yes, complete and submit another DHS 1640**

ALLEGED PERPETRATOR (AP)

(If Self Neglect, skip section)

Name (Last, First, M.I., nicknames, alias, or name of facility):

Date of Birth / Age:

Gender: ☐ Male ☐ Female ☐ Other

Relationship to alleged victim: ☐ Offspring: ☐ Other relative: ☐ Service Provider: ☐ Staff of Care Facility: ☐ Other:

Home Address: (Street address, unit number)

City	State	Zip Code	Island

Phone Numbers:

Home: Work:

Cellular: Other:

Work Address: (Business Name, Street, Unit Number, City, Zip Code, Island)

Ethnicity:

Primary Language Spoken, if known:

Interpreter needed? ☐ Yes ☐ No ☐ Unknown

Are there other alleged perpetrators? ☐ Yes ☐ No **If yes, please attach additional pages as necessary**

ALLEGED ABUSE INFORMATION

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

DATE(S) OF INCIDENT:

LOCATION(S) OF INCIDENT (Name of facility, if applicable):

☐ Own Home
☐ Adult Residential Care Home (ARCH)
☐ Assisted Living Facility
☐ Community Care Foster Family Home
☐ Developmental Disabilities Home
☐ Expanded ARCH
☐ Hospital
☐ Nursing Facility
☐ Offspring Home
☐ Other Relative Home
☐ Unknown
☐ Other:

ABUSE INDICATORS: (alphabetical after first two boxes)

☐ Death
☐ Immediate risk of death
☐ Afraid
☐ Broken bone(s)
☐ Bruising - substantial / multiple
Discoloration / color:
☐ Burn
☐ Change in behavior or appearance
☐ Controlled by AP / others (suspected)
☐ Decubitus ulcer (bedsore)
Measurement:
☐ Failure to provide in a timely manner
☐ Food, shelter, or clothing
☐ Necessary care / health care
☐ Necessary supervision
☐ Hit or slapped
☐ Injury - substantial bleeding
☐ Injury – suspicious
☐ Isolated
☐ Malnourished
☐ Mental or emotional distress
☐ Misuse of medications
☐ Misuse / taking of AV's assets / property
☐ Nervous, anxious
☐ Poor grooming / hygiene
☐ Pornographic photography / filming
☐ Restraint – improper
☐ Sexual abuse evidence
☐ Sexual assault / molestation
☐ Threatened or intimidated
☐ Unable to care for self
☐ Unable to manage finances
☐ Unable to obtain essential needs
☐ Unsafe living environment

Please check all that apply: ☐ **AP access to AV** ☐ **AP access to AV's assets** ☐ **AP is also a vulnerable adult**

NARRATIVE INFORMATION: (Attach additional pages if needed)

Please provide detailed information about the alleged abuse and concerns. For example:

- Describe the incident in detail. Clarify if you personally witnessed the incident or explain how you know this information.
- Describe any injury to the alleged victim in as much detail as possible (example: type of injury, size, color, location, shape, quantity).
- Did the alleged victim receive medical treatment? Please provide date / location of ER visit or hospitalization, if applicable.

Please provide any other information that may be helpful in establishing the cause of the alleged abuse.
Please identify other person(s) believed to have witnessed or have knowledge of the abuse and provide available contact information. (Example: partner, family, friends, neighbors, health care / service providers, bank tellers, or other facility residents.)
If first responders or law enforcement were contacted, please provide name, contact, and any available report numbers.

SERVICES / TREATMENT

Check all applicable services / treatment that are received by, or were offered to the AV or AP.

Please identify the service / treatment provider(s) and contact information in the space below.

	Alleged Victim (AV)		Alleged Perpetrator (AP)	
☐ Medical Treatment	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Behavioral Health Treatment	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Substance Abuse Treatment	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Developmental Disabilities Division	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Case Management Services	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Adult Day Care / Day Health	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Domestic Violence Services	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Legal Services	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Public Health Nursing	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ APS involvement (Hawaii or elsewhere)	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Financial Management Services	☐ Received	☐ Offered	☐ Received	☐ Offered
☐ Other (specify):	☐ Received	☐ Offered	☐ Received	☐ Offered

Provider (name/agency) and contact information/number:

ALLEGED VICTIM SUPPORT SYSTEM

Sources of support. List name(s) and contact information in the space below.

☐ Spouse ☐ Parent ☐ Other Family Member: ☐ Community groups / church
☐ Child ☐ Sibling ☐ Friend ☐ Other (specify):

Name(s), relationship to alleged victim, and contact information:

POTENTIAL HAZARDS

Identify potential hazards and who is the source of the concern. Please clarify and provide additional information below.

	Alleged Victim (AV)	Alleged Perpetrator (AP)	Other (name/relationship to AV)
☐ Aggressive / Violent	☐	☐	☐
☐ Animals – aggressive:	☐	☐	☐
☐ Communicable disease:	☐	☐	☐
☐ Criminal activity:	☐	☐	☐
☐ Environmental concerns:	☐	☐	☐
☐ Weapons (type and location):	☐	☐	☐
☐ Health factors (biohazard, chemicals, asbestos)	☐	☐	☐
☐ Substance use:	☐	☐	☐
☐ Untreated mental illness:	☐	☐	☐
☐ Other:	☐	☐	☐

Please attach any additional information. THANK YOU FOR YOUR ASSISTANCE.

Signature of Reporter **Date**