R.I. Department of Elderly Affairs

PROTECTIVE SERVICES REFERRAL FORM

For Professional Use Only

PLEASE PRINT OR TYPE AND RETURN TO:

FAX #462-0545

DATE: _____

CLIENT INFORMATION

CLIENT NAME: _____ GENDER: [ ]Male [ ]Female

(last) (first) ETHNICITY:

ADDRESS: _____ [ ] Hispanic or Latino

APT. NAME: _____ [ ] Not Hispanic or Latino

APT.# or FLOOR: _____ [ ] Unknown

CITY/TOWN/ZIP: _____ Is client English speaking? [ ]Yes [ ]No

PHONE #: _____ If NO, what is primary language? _____

D.O.B.: _____ Is an Interpreter needed? [ ]Yes [ ]No

AGE: (must be 60 or over) _____ ***CLIENT***

SS#: _____ ***CONTACTS:*** _____

_____

****PLEASE NOTE THAT THE 9-DIGIT***

SS# IS REQUIRED*** Does client live alone? [ ]Yes [ ]No

Is there evidence that the client has problems with Substance Abuse? [ ]Yes [ ]No

Is there evidence of any Potential Contagious Disease? [ ]Yes [ ]No

ALLEGED PERPETRATOR INFORMATION (if applicable)

Name of Person Responsible for Alleged Abuse/Neglect/Exploitation: _____

Relationship to Client: _____

Does He or She Reside With Client?: (please check) [ ]Yes [ ]No

If **NO,** Address: _____

_____

Phone #: _____

Is there any evidence of alleged perpetrator Substance Abuse? [ ]Yes [ ]No

If reason for referral is criminal in nature, was Alleged Perpetrator charged? [ ]Yes [ ]No

REPORTER INFORMATION

YOUR NAME: _____ AGENCY: _____

TITLE: _____ PHONE: _____

***** Please note the your referral will be reviewed and a determination will be made upon review if the referral meets DEA Protective Service criteria. If further information is needed for said determination, we will contact you via telephone or fax. Thank you. *****

PLEASE USE ATTACHED 2ND PAGE FOR NARRATIVE

R.I. Department of Elderly Affairs

PROTECTIVE SERVICES REFERRAL FORM

For Professional Use Only

NARRATIVE

PLEASE PRINT OR TYPE

CLIENT NAME: _____

SIGNED: _____