**Teacher Instructions**

Students will use an elder abuse scenario to complete an elder abuse form. Read scenario A, 3 times following these instructions.

1. Read Scenario A slowly, students listen closely without writing notes.
2. Distribute the Elder Abuse Report Scenario Practice A Handout. Allow students to read the handout. Read Scenario A, a second time at a regular pace. Using the handout, students should write notes of the important information. They should not write exactly what they hear since this is not a dictation activity.
3. Read a third time at a regular pace while students check and edit their notes.
4. Distribute the report of suspected dependent adult/elder abuse forms for students to complete.

**Scenario A:**

Your consumer is Wei Ying Zhang. At 8am he told you that a few weeks ago his son took all his savings without permission. Now, he doesn’t have money to pay the rent or buy groceries. He is very depressed.

**Elder Abuse Report Scenario Practice A**

Directions: Read the following information and complete an Elder Abuse Report using the information below and the story read by your teacher.

You are a Personal Care Aide for A-Plus Caregiving in San Gabriel. You suspect elder abuse. Today, after speaking to your supervisor, you verbally reported your suspicion to Amanda Garcia at Adult Protective Services (APS) 800-477-3646 at 3:30pm. Now you need to complete a written report. Your employer is:

A-Plus Caregiving

1586 San Gabriel Blvd.

San Gabriel, CA 91775

800-555-6547

Apluscaregiving@gmail.com



* lives alone
* widower
* son, John Zhang lives in Pasadena
* family in Virginia
* son is a gambler
* has very little food in the house
* depressed
* SSA Retirement Income
* Chinese
* SS# 123-45-6789
* 626-555-4321
* Speaks Mandarin and English

**Notes**

What is the abusive situation?

When did it occur (date/time)?

Who is the abuser (if any)?

What is the danger?

How often has it occurred?

What is the consumer’s current health?

**REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE**

Date Completed

**CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE** *TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.*

1. **VICTIM** Check box if victim consents to disclosure of information (Ombudsman use only - WIC 15636(a))

|  |  |  |  |
| --- | --- | --- | --- |
| Name (Last Name, First Name) | Age | Date of Birth | SSN |
| Gender Identity* Male
* Female
* Transgender
* Other/Nonbinary
* Unknown/Not Provided
 | Sexual Orientation* Straight
* Gay/Lesbian
* Bisexual
* Questioning
* Unknown/Not Provided
 | Ethnicity | Race |
| Language (Check one) Non-Verbal EnglishOther (Specify)  |
| Address(If facility, include name and notify ombudsman) | City | Zip Code | Telephone |
| Present Location(If different from above) | City | Zip Code | Telephone |
| Elderly (65+) Developmentally Disabled Mentally Ill/Disabled Physically Disabled Unknown/Other | * Lives Alone
* Lives with Others
 |

1. **SUSPECTED ABUSER** Check if \_Self-Neglect or Name of Suspected Abuser \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Address | City | Zip Code | Telephone |

Care Custodian (Type) Parent Son/Daughter Other

Health Practitioner (Type) Spouse Other Relation

|  |  |  |  |
| --- | --- | --- | --- |
| GenderMale Female | Ethnicity | Age | D.O.B. |
| Height | Weight | Eyes | Hair |

# REPORTER’S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? DOES THE ALLEGATION INVOLVE A SERIOUS BODILY INJURY (see definition in section “Reporting Responsibilities and Time Frames” within the General Instructions)? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.) or concerns about the client’s mental health.

CHECK IF MEDICAL, FINANCIAL (ACCOUNT INFORMATION, ETC.), PHOTOGRAPHS, OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

1. **REPORTING PARTY** Check appropriate box if reporting party waives confidentiality to

All All but victim All but perpetrator

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Signature | Occupation | Agency/Name of Business |
| Relation to Victim/How Abuse is Known | Street | City | Zip Code |
| Telephone | E-mail Address |

1. **INCIDENT INFORMATION -** Address where incident occurred

|  |
| --- |
| Date/Time of Incident(s) |
| Place of Incident (Check One)Own Home Community Care Facility Hospital/Acute Care HospitalHome of Another Nursing Facility/Swing Bed Other (Specify)  |

1. **REPORTED TYPES OF ABUSE** (Check All that Apply)

|  |
| --- |
| 1. Perpetrated by Others (WIC 15610.07 & 15610.63)1. Physical (e.g. assault/battery, constraint or e. Abandonment deprivation, chemical restraint, over/under medication) f. Isolation
2. Sexual g. Abduction
3. Financial h. Psychological/Mental
4. Neglect (including Deprivation of Goods and Services i. Other by a Care Custodian)
 |
| 2. Self-Neglect (WIC 15610.57 (b)(5))1. Neglect of Physical Care (e.g. personal hygiene, c. Financial Self-Neglect

food, clothing, malnutrition/dehydration) (e.g. inability to manage one’s own1. Self-Neglect of Residence (unsafe environment) personal finances)
 |
| Abuse Resulted In (Check All that Apply)No Physical Injury Minor Medical Care Hospitalization Care Provider RequiredDeath Mental Suffering Serious Bodily Injury\* Other (Specify) Unknown Health & Safety Endangered |

# OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE

*(Family, significant others, neighbors, medical providers, agencies involved, etc.)*

|  |  |
| --- | --- |
| Name | Relationship |
| Address | Telephone |

# FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM’S CARE

*(If known, list contact person)* If Contact person check

|  |  |
| --- | --- |
| Name | Relationship |
| Address | City | Zip Code | Telephone |

1. **TELEPHONE REPORT MADE TO** APS Law Enforcement Local Ombudsman Calif. Dept. of State Hospitals Calif. Dept. of Developmental Services

|  |  |  |
| --- | --- | --- |
| Name of Official Contacted by Phone | Telephone | Date/Time |

1. **WRITTEN REPORT** Enter information about the agencies receiving this report. If the abuse occurred in a LTC facility and resulted in Serious Bodily Injury\*, please refer to “Reporting Responsibilities and Time Frames” in the General Instructions. Do not submit report to California Department of Social Services Adult Programs Division.

|  |  |  |  |
| --- | --- | --- | --- |
| Agency Name | Address or Fax |  Date Mailed |  Date Faxed |
| Agency Name | Address or Fax |  Date Mailed |  Date Faxed |
| Agency Name | Address or Fax |  Date Mailed |  Date Faxed |

1. **RECEIVING AGENCY USE ONLY** Telephone Report Written Report

|  |  |
| --- | --- |
| 1. Report Received By | Date/Time |
| 2. Assigned Immediate Response Ten-Day Response No Initial Response (NIR) Not APS Not Ombudsman No Ten-Day (NTD) |
| Approved By | Assigned To (optional) |
| 3. Cross-Reported to CDPH-Licensing & Cert.; CDSS-CCL; Local Ombudsman; Bureau of Medi-Cal Fraud & Elder Abuse;Calif. Dept. of State Hospitals; Law Enforcement;Professional Licensing Board; Calif. Dept. of Developmental Services; APS; Other (Specify) Date of Cross-Report  |
| 4. APS/Ombudsman/Law Enforcement Case File Number |