Abuse Allegation Report
Community Services Board

Abuse #: Alleged Abuse Date: Medicaid Number:

Individual Name: Individual ID #: SSN:

Gender: Race: Waiver Type: DOB:

Case Management CSB: Is Individual receiving a Waiver here?

Service Type:

Location:

Specific Site:

Substitute Decision Maker:

Relation:

	Physical	Sexual	Verbal	Neglect	Neglect Peer to Peer	Exploitation	Seclusion/ Restraint	Other
Abuse Alleged:	☐	☐	☐	☐	☐	☐	☐	☐
Abuse Occurred:	☐	☐	☐	☐	☐	☐	☐	☐

Type of Restraint:

Description:

Prior to May 2010, see Did Abuse Occur?

Consumer Address:

Consumer Phone #:

Injuries

Individual Injured?:

Type of Injury: ☐ Bruises ☐ Fractures ☐ Lacerations ☐ Burns ☐ Death ☐ Other

Medical Attention Provided? Medical Attention Type:

Description of Medical Treatment Provided & Finding:

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Reporting:

Date Allegation Made:

Who Made Allegation: Title:

Reported to Whom: Title:

Who Reported to Director: Date Reported:

Investigation:

Investigation Begin Date Investigation Final Report::

Date: Investigator Name:

Rationale:

Decision Date:

Other Rationale:

Reason for Corrective Action:

Corrective Action Taken:

Notification of Findings and Right to Appeal Dates:

Individual: Substitute Decision Maker: Advocate:

Responsible Advocate:

Case Status:

Case Status:

Date Case Closed: Report Closed By:

Point of Resolution:

Resolution:

Notification Dates and Times:

Director:

Licensing:

Advocate:

Sub. Dec. Maker:

DMAS:

Other: If other, who:

Department of Social Services

DSS Person:

Date Time Notified:

Method of Notification:

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DSS Findings:

Polices

Suspected Criminal Activity:

Local Police Notification:

Date: Name: Dept:

State Police Notification:

Date: Person: Dept:

Abused Accused

Name: Position:

State Employee ID: Date of Birth:

Actions Taken:

☐ Terminated ☐ Resigned ☐ Written Counseling ☐ Refer to Judicial System

☐ Transferred ☐ Remedial ☐ Monitor ☐ Not DBHDS Employee

☐ Suspended ☐ Verbal Counseling ☐ No Action ☐ Other

Action Remark:

Witness
Witness Name:

Abuse AAR

Advocate Report Date:

Remarks:	Description:

LHRC

Review\Request Date: Review Requested By:

Hearing Request Date:

☐ Review Request Withdrawn ☐ Extension Granted

Decision:

☐ Violation ☐ No Violation ☐ Made Recommendation ☐Other

Appeal To SHRC: ☐

Decision Date:

Remarks:

Abuse SHRC

Review\Request Date:

SHRC Review Request By: ☐ Advocate ☐ Director ☐ Individual ☐ Auth Rep ☐ Other

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Hearing Date:

☐ Withdrawn ☐ Extension ☐ Denied

Decision:

☐ Violation ☐ No Violation ☐ Concurrent with LHRC ☐ Make Recommendation ☐ Other

Decision Date: ☐ Novo

Commisioner

Commissioner Notification Date:

Commissioner Action Date:

Commisioner Action:
Commissioner response:

Remarks