

**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.

**A. 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<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Transgender<br><input type="checkbox"/> Other/Nonbinary<br><input type="checkbox"/> Unknown/Not Provided |  | Sexual Orientation<br><input type="checkbox"/> Straight<br><input type="checkbox"/> Gay/Lesbian<br><input type="checkbox"/> Bisexual<br><input type="checkbox"/> Questioning<br><input type="checkbox"/> Unknown/Not Provided  |               | Ethnicity<br><br>Language (Check one)<br><input type="checkbox"/> Non-verbal <input type="checkbox"/> English<br><input type="checkbox"/> Other (Specify) _____ |
| Race                                                                                                                                                                                                                     |  | Address<br>(If facility, include name and notify ombudsman)                                                                                                                                                                    |               | City                                                                                                                                                            |
| Zip Code                                                                                                                                                                                                                 |  | Telephone                                                                                                                                                                                                                      |               |                                                                                                                                                                 |
| Present Location<br>(If different from above)                                                                                                                                                                            |  | City                                                                                                                                                                                                                           |               | Zip Code                                                                                                                                                        |
| Telephone                                                                                                                                                                                                                |  | <input type="checkbox"/> Elderly (60+) <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Mentally Ill/Disabled<br><input type="checkbox"/> Physically Disabled <input type="checkbox"/> Unknown/Other |               | <input type="checkbox"/> Lives Alone<br><input type="checkbox"/> Lives with Others                                                                              |

**B. SUSPECTED ABUSER**    Check if  Self-Neglect

Name of Suspected Abuser \_\_\_\_\_

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

Care Custodian (Type) \_\_\_\_\_     Parent     Son/Daughter     Other \_\_\_\_\_

Health Practitioner (Type) \_\_\_\_\_     Spouse     Other Relation \_\_\_\_\_

|                                                                         |           |     |       |
|-------------------------------------------------------------------------|-----------|-----|-------|
| Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Ethnicity | Age | D.O.B |
|-------------------------------------------------------------------------|-----------|-----|-------|

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| Height | Weight | Eyes | Hair |
|--------|--------|------|------|
|--------|--------|------|------|

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**C. 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.

**D. 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 |            |                         |

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

Date/Time of Incident(s)

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Place of Incident (Check One)  
 Own Home  Community Care Facility  Hospital/Acute Care Hospital  
 Home of Another  Nursing Facility/Swing Bed  Other (Specify) \_\_\_\_\_

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

1. Perpetrated by Others (WIC 15610.07 & 15610.63)
- |                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| a. <input type="checkbox"/> Physical (e.g. assault/battery, constraint or deprivation, chemical restraint, over/under medication)<br>b. <input type="checkbox"/> Sexual<br>c. <input type="checkbox"/> Financial<br>d. <input type="checkbox"/> Neglect (including Deprivation of Goods and Services by a Care Custodian) | e. <input type="checkbox"/> Abandonment<br>f. <input type="checkbox"/> Isolation<br>g. <input type="checkbox"/> Abduction<br>h. <input type="checkbox"/> Psychological/Mental<br>i. <input type="checkbox"/> Other _____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
2. Self-Neglect (WIC 15610.57 (b)(5))
- |                                                                                                                                                                                                      |                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| a. <input type="checkbox"/> Neglect of Physical Care (e.g. personal hygiene, food, clothing, malnutrition/dehydration)<br>b. <input type="checkbox"/> Self-Neglect of Residence (unsafe environment) | c. <input type="checkbox"/> Financial Self-Neglect (e.g. inability to manage one’s own personal finances) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|

Abuse Resulted In (Check All that Apply)  
 No Physical Injury  Minor Medical Care  Hospitalization  Care Provider Required  
 Death  Mental Suffering  Serious Bodily Injury\*  Other (Specify) \_\_\_\_\_  
 Unknown  Health & Safety Endangered

**G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE**

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

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

**H. 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 |

**I. 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 |
|-------------------------------------|-----------|-----------|

**J. 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 | <input type="checkbox"/> Date Mailed | <input type="checkbox"/> Date Faxed |
| Agency Name | Address or Fax | <input type="checkbox"/> Date Mailed | <input type="checkbox"/> Date Faxed |
| Agency Name | Address or Fax | <input type="checkbox"/> Date Mailed | <input type="checkbox"/> Date Faxed |

**K. 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

California Dept. of State Hospitals;  Law Enforcement

Professional Licensing Board;  California Dept. of Developmental Services;

APS; Other(Specify) \_\_\_\_\_

4. APS/Ombudsman/Law Enforcement Case File Number

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**REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE  
GENERAL INSTRUCTIONS****PURPOSE OF FORM**

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. **Abuse** means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. **Neglect** means the negligent failure of an elder or dependent adult or of any person having the care or custody of an elder or a dependent adult to exercise that degree of self-care or care that a reasonable person in a like position would exercise. For purposes of mandatory reporting, **elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

**COMPLETION OF THE FORM**

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

**REPORTING RESPONSIBILITIES AND TIME FRAMES:**

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

**\*Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury, report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.
- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential Internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
  - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
  - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.
- For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

**REPORTING PARTY DEFINITIONS**

**Mandated Reporter** (WIC Section 15630 (a)) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

**Care Custodian** (WIC Section 15610.17) means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code; (b) Clinics; (c) Home health agencies; (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services; (e) Adult day health care centers and adult day care; (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders; (g) Independent living centers; (h) Camps; (i) Alzheimer's Disease Day Care Resource Centers; (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code; (k) Respite care facilities; (l) Foster homes; (m) Vocational rehabilitation facilities and work activity centers; (n) Designated area agencies on aging; (o) Regional centers for persons with developmental disabilities; (p) State Department of Social Services and State Department of Health Services licensing divisions; (q) County welfare departments; (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys; (s) The Office of the State Long-Term Care Ombudsman; (t) Offices of public conservators, public guardians, and court investigators; (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities; or (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness; (v) Humane societies and animal control agencies; (w) Fire departments; (x) Offices of environmental health and building code enforcement; or (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

**Health Practitioner** (WIC Section 15610.37) means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.



Any officer and/or employee of a financial institution is a mandated reporter of suspected financial abuse and shall report suspected financial abuse of an elder or dependent adult on form SOC 342, "Report of Suspected Dependent Adult/Elder Financial Abuse".

### **MULTIPLE REPORTERS**

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

### **IDENTITY OF THE REPORTER**

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

### **FAILURE TO REPORT**

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder (age 65 or older) or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than \$1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder (age 65 or older) or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to \$5,000, or by both imprisonment and fine (WIC Section 15630(h)).

No one, including a supervisor, employer, or lawyer, can excuse a mandated reporter from his or her personal legal duty to report known or suspected abuse. Anyone who attempts to impede or inhibit a mandated reporter from reporting may be prosecuted for a misdemeanor punishable by a fine, imprisonment, or both. Mandated reporters are therefore expected to report any such efforts to law enforcement, as well as any other responsible agency (see Welfare and Institutions Code Section 15630(f) and (h)).

Officers or employees of financial institutions are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding \$1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding \$5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter, to the party bringing the action.

### **ADULT PROTECTIVE SERVICES ELIGIBILITY**

For purposes of eligibility to receive services under the APS program, an elder is defined as anyone residing in this state 60 years of age or older. (WIC Section 15750(b)(2)). As of January 1, 2022, APS agencies can receive referrals and investigate allegations of abuse and provide intervention and case management to any elder 60 years of age or older, and to dependent adults between the ages of 18-59(WIC Section 15750(b)(1)(A)).

Statutes governing mandated reporting have not been affected; accordingly, mandatory reporting still only

applies to elders age 65 years and older. DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency or agencies, the reporter shall send the written report to the designated agencies (as defined under “Reporting Responsibilities and Time Frames”); and keep one copy for the reporter’s file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.

**DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS DIVISION.**