ElderSAFE Center Intake Form

ElderSAFE Identification # __________________________ CESLC Resident # _______________________

Date of Referral □ or Inquiry □ ___________________________ Time of Call ________ □ AM □ PM

Date Shelter Offered ___________________________ Date Shelter Declined ___________________________

Date of Admission ___________________________ Date of Discharge ___________________________

Provided Community Resources ________________________________________________________________

Follow-up Provided Following Discharge □ Yes □ No □ N/A Date of Follow-up: _______________________

ElderSAFE Staff Completing Intake _____________________________________________________________

(This section is completed by an ElderSAFE Center staff)

Referral or Inquiry Information:

Name and title of person making referral or inquiry _______________________________________________

Phone __________________ Fax __________________ e-mail ______________________________

How did referring agency hear about ElderSAFE? _______________________________________________

Has abuse been reported to police? __________________________________________________________

Has abuse been reported to APS? __________________________________________________________

Does the victim or anyone that he or she knows work or volunteer at the Hebrew Home currently or in the past? □ Yes □ No □ Unknown. If yes, please provide full name: ______________________________

Agency or program making referral:

□ Adult Protective Services □ Hospital □ State’s Attorney’s Office □ Community Program

□ Other ______________________________

Jurisdiction of agency or program:

Maryland:

□ Montgomery County □ Prince George’s County □ Howard County

□ Baltimore County □ Baltimore City □ Anne Arundel County

□ Other ______________________________

District of Columbia: □

Virginia: □ Fairfax County □ Arlington County □ Other__________________________

Updated: Aug 15, 2016
**Demographic Information of Victim:**

First Name ________________________ MI. __________ Last Name__________________________

- Male
- Female

Date of Birth _______________ Social Security #________________________

Address: ____________________________________________________________

_________________________________________________________________

Type of Abuse:

- Physical
- Sexual
- Psychological
- Neglect
- Financial

Specific date of last incident: __________________________________________

Briefly describe last incident: __________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

Does victim have a current protective order?  

- Yes
- No

If not, is the victim interested in getting a protective order?  

- Yes
- No

Does the victim speak/understand English?  

- Yes
- No

If not, primary language____________________

Home Phone ______________ Is it safe to contact?  

- Yes
- No

Cell Phone ______________ Is it safe to contact?  

- Yes
- No

E-mail ______________________ Is it safe to contact?  

- Yes
- No

Married  

- Yes  

- No

Dating Partner  

- Yes  

- No

Living Together  

- Yes  

- No

Spiritual Preference __________________________________________________________________

Emergency contact name _____________________________________________________________

Relationship to victim _____________________ Phone _________________________________

Is it safe to contact this person?  

- Yes
- No

**Insurance Information:**

Medicare  

- Yes
- No  

State ______  

Identification # ________________________________

Medicaid  

- Yes
- No  

State ______  

Identification # ________________________________

Other insurance ___________________________  

Identification # ________________________________
**Jurisdictional Information:**
Abuse is taking place at the following address ____________________________________________
What kind of setting is this? (Private house, long term care, etc.) ____________________________
Jurisdiction where abuse is taking place:

**Maryland:**
- ☐ Montgomery County
- ☐ Prince George’s County
- ☐ Howard County
- ☐ Baltimore County
- ☐ Baltimore City
- ☐ Anne Arundel County
- ☐ Other __________________

**District of Columbia:** ☐

**Virginia:** ☐ Fairfax County
- ☐ Arlington County
- ☐ Other __________________

**Medical Information:** (Please provide most recent medical record if available)
List of medical conditions

________________________________________________________
________________________________________________________

List of medications

________________________________________________________
________________________________________________________

Allergies to medications

________________________________________________________

List and date of recent hospitalizations

________________________________________________________

Was hospitalization due to abuse? ___________________________________________________________

List of psychological conditions and if so, is the victim currently receiving mental health treatment?

________________________________________________________
________________________________________________________

History of substance abuse or alcohol abuse

________________________________________________________
________________________________________________________

Social history, including potential for violence and suicidal ideation

________________________________________________________
________________________________________________________

**Legal Information:**
Legal Guardian ☐ Yes ☐ No ☐ N/A
Name: ____________________________ Phone #______________________

Power of Attorney for Finances ☐ Yes ☐ No ☐ N/A
Name: ____________________________ Phone #______________________

Power of Attorney for Healthcare ☐ Yes ☐ No ☐ N/A
Name: ____________________________ Phone #______________________

Updated: Aug 15, 2016
**Information regarding abuser:**

Name of person committing abuse ___________________________ DOB ____________
(Please provide a photo of this person if possible)

Address of person committing abuse ____________________________________________

Vehicle information of abuser: License plate# ______________ make __________ model __________
color ____________ year __________

Does person committing abuse have access to guns or weapons?  
  □ Yes  □ No  □ Unknown

Does person committing the abuse has a criminal history?  
  □ Yes  □ No  □ Unknown

Does person committing the abuse has any of the following problems?

  - Mental health diagnosis  □ Yes  □ No  □ Unknown ________________________________
  - Alcohol abuse  □ Yes  □ No  □ Unknown ________________________________
  - Substance abuse  □ Yes  □ No  □ Unknown ________________________________

Is there a court order in place?  
  □ Yes  □ No  □ Protective □ Peace □ Trespass (Please provide copies of order to ElderSAFE Center if possible)

Are there any other individuals currently or in the past who have been accused of abusing victim?  
  □ Yes  □ No  □ Unknown

  If yes, please explain: ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________

**Other important information to share:**

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

**Additional Notes:**

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

FAX to 301.770.8327

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