RON 12-23-2013

1. REPORTER'S DETAILS

1.A. CONSUMER'S INFORMATION

1. Date RON Received

_____/_____/_____

2. Time RON Received

_____

3. Date(s) of the incident(s)

_____

4. LAST Name

_____

5. FIRST Name

_____

6. MIDDLE Initial

_____

7. Name SUFFIX (if applicable)

_____

1.B. CONSUMER'S DEMOGRAPHIC DATA

1. What type of communication assistance will be needed to communicate with consumer?

- ☐ Language
- ☐ Language and Mechanical
- ☐ Mechanical
- ☐ American Sign Language (ASL)
- ☐ None/Not Reported

2. Primary Language

- ☐ American Sign Language
- ☐ English
- ☐ Russian
- ☐ Spanish
- ☐ Other-Document in Notes

3. Date of Birth (DOB) (If unknown, document an estimated age in Notes)

_____/_____/_____

4. Marital Status

- ☐ Divorced
- ☐ Married
- ☐ Single
- ☐ Separated
- ☐ Widowed
- ☐ Other-Document Details in Notes
- ☐ Unavailable/Unknown

5. Gender

- ☐ Female
- ☐ Male

6. Social Security Number (SSN) (Optional)

_____-_____-_____

7. Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

8. Race(s)

- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Non-Minority (White, Non-Hispanic)
- ☐ White-Hispanic
- ☐ Other-Document in Notes
- ☐ Unavailable

9. Current Living Arrangement (Include in the "Lives Alone" category, Consumers who live in AL, Dom Care, and PCH, pay rent, or have no roommate.)

- ☐ Lives Alone
- ☐ Lives with Spouse Only
- ☐ Lives with Child(ren) but not Spouse
- ☐ Lives with Other Family Member(s)
- ☐ Other-Document Details in Notes
- ☐ Don't Know

10. CONSUMER'S type of residence at time of reported event.

- [ ] Apartment
- [ ] Assisted Living (AL)
- [ ] CRR (Mental Health)
- [ ] Caretaker/Caregiver's Home
- [ ] Community Homes for Individuals with ID
- [ ] Domicilliary Care Home (DC)
- [ ] Family Living/Shared Living
- [ ] Homeless
- [ ] Long Term Structured Residence (LTSR/MH) Mental Health
- [ ] Inpatient Psychiatric Facility
- [ ] Intermediate Care Facility (ICF)
- [ ] Nursing Facility
- [ ] Own Home
- [ ] Personal Care Home (PCH)
- [ ] Other-Document Details in Notes
- [ ] Unknown

11. Identify where the incident occurred. If County is different than residence, document details in notes.

_____

1.C. CONSUMER'S RESIDENTIAL ADDRESS INFORMATION

1. Name of facility, if residing in a facility. (If not residing in a facility, document as N/A.)

_____

_____

_____

_____

2. RESIDENTIAL Street Address (Include number of house, apartment, or room.)

_____

3. RESIDENTIAL Street Address Second Line (if needed)

_____

4. RESIDENTIAL City or Town (Optional and must be located within the required residential municipality.)

_____

5. RESIDENTIAL Municipality - REQUIRED (Usually a Township or Borough where Consumer Votes, Pays Taxes.)

_____

6. RESIDENTIAL County – REQUIRED

- [ ] Adams
- [ ] Allegheny
- [ ] Armstrong
- [ ] Beaver
- [ ] Bedford
- [ ] Berks
- [ ] Blair
- [ ] Bradford
- [ ] Bucks
- [ ] Butler
- [ ] Cambria
- [ ] Cameron
- [ ] Carbon
- [ ] Centre
- [ ] Chester
- [ ] Clarion
- [ ] Clearfield
- [ ] Clinton
- [ ] Columbia
- [ ] Crawford
- [ ] Cumberland
- [ ] Dauphin
- [ ] Delaware
- [ ] Elk
- [ ] Erie
- [ ] Fayette
- [ ] Forest
- [ ] Franklin
- [ ] Fulton
- [ ] Greene
- [ ] Huntingdon
- [ ] Indiana
- [ ] Jefferson
- [ ] Juniata
- [ ] Lackawanna
- [ ] Lancaster
- [ ] Lawrence
- [ ] Lebanon
- [ ] Lehigh
- [ ] Luzerne
- [ ] Lycoming
- [ ] McKean
- [ ] Mercer
- [ ] Mifflin
- [ ] Monroe
- [ ] Montgomery
- [ ] Montour
- [ ] Northampton
- [ ] Northumberland
- [ ] Perry
- [ ] Philadelphia
- [ ] Pike
- [ ] Potter
- [ ] Schuylkill
- [ ] Snyder
- [ ] Somerset
- [ ] Sullivan
- [ ] Susquehanna
- [ ] Tioga
- [ ] Union
- [ ] Venango
- [ ] Warren
- [ ] Washington
- [ ] Wayne
- [ ] Westmoreland
- [ ] Wyoming
- [ ] York
- [ ] Out Of State

7. CONSUMER'S Primary Telephone Number

_____

8. DIRECTIONS to Consumer's Location (Optional)

_____

_____

_____

_____

9. NAME of Emergency Contact

_____

10. PHONE Number of Emergency Contact

_____

11. NAME of Primary Care Physician

_____

12. Business PHONE Number for Primary Care Physician

_____

1.D. CONSUMER'S POSTAL/MAILING ADDRESS INFORMATION

1. POSTAL Street Address (Include number of PO Box, street, house, apartment, OR room.)

_____

2. POSTAL Address Second Line (if needed)

_____

3. POSTAL City or Town

_____

4. POSTAL State

_____

5. POSTAL Zip Code

_____

2. REPORTER'S OBSERVATIONS

2.A. CONSUMER'S CURRENT SITUATION

1. Identify ALL ALLEGATIONS made by the reporter. Document ALL Details provided regarding EACH ALLEGATION in the Notes section.

- [ ] Physical abuse
- [ ] Emotional abuse
- [ ] Self neglect
- [ ] Caretaker/Caregiver neglect
- [ ] Exploitation
- [ ] Abandonment
- [ ] Sexual abuse

2. Is the consumer in a life threatening situation?

- [ ] Yes
- [ ] No
- [ ] Unknown

3. Reported physical and health conditions of consumer - Document ALL Details in Notes.

- [ ] None/Not reported
- [ ] Amputation
- [ ] Arthritis
- [ ] Functional limitations
- [ ] Medication mismanagement (ie. undermedicated, substance abuse)
- [ ] Physical trauma (ie. bruises, cuts, burns, signs of sexual abuse)
- [ ] Poor personal hygiene (ie. dirty, odorous, poor dental health)
- [ ] Poor nutritional status (ie. malnourished, dehydrated, weight loss)
- [ ] Recent hospitalizations (ie. hospitalized in last 30 days)
- [ ] Unmet personal needs (ie. lack of false teeth, eyeglasses, hearing aid)
- [ ] Untreated medical condition (ie. ulcerations, bedsores)
- [ ] Other-Document Details in Notes
- [ ] Unknown

4. Type of disability(ies) reported:

- [ ] None/Not Reported
- [ ] ALS (Lou Gehrig's)
- [ ] Alzheimer's/Dementia
- [ ] Autism Spectrum Disorder
- [ ] Blind/Visually Impaired
- [ ] Brain Injury (Traumatic/Acquired)
- [ ] Chemical Dependency, including Alcohol and Substance Abuse
- [ ] DD/ID
- [ ] Deaf/Hearing Impaired
- [ ] Epilepsy
- [ ] Mental Illness
- [ ] Medical Diagnoses Leading to Physical Disability
- [ ] Physical Disability
- [ ] Speech Impairment
- [ ] Other-Document Details in Notes
- [ ] Unknown

5. Indicate the types of substance abuse:

- [ ] None/Not reported
- [ ] Alcohol
- [ ] Illegal drugs
- [ ] Misusing prescribed medications
- [ ] Other-Document Details in Notes

6. Reported emotional and mental conditions of Consumer - Document all Details in Notes.

- [ ] None/Not Reported
- [ ] Confusion (ie. memory loss, wandering)
- [ ] Disoriented (ie. to person, place, or time)
- [ ] Feels threatened or intimidated
- [ ] Hallucinations (ie. hearing voices, seeing non-existent objects or people)
- [ ] Recent suicidal talk/actions/thoughts
- [ ] Unable to communicate and/or comprehend
- [ ] Other-Document Details in Notes
- [ ] Unknown

7. Reported problems with the physical environment of Consumer - Document all Details in Notes.

- [ ] None/Not reported
- [ ] Architectural barriers (ie. inaccessible, bathroom, stairway)
- [ ] Garbage/trash accumulation
- [ ] Inadequate utilities (ie. heat, plumbing)
- [ ] In need of repair
- [ ] Insect/pest problem(s)
- [ ] Pet/animal problem(s) (ie. overpopulation, inadequate care)
- [ ] Safety hazard(s) (ie. fire danger, leaky roof)
- [ ] Other-Document Details in Notes
- [ ] Unknown

8. Note any dangers - Document Details in Notes.

- [ ] None/Not reported
- [ ] History of Violent Behavior in Home
- [ ] Gang Activity
- [ ] Neighborhood Dangers
- [ ] Known Drug Activity
- [ ] Pets
- [ ] Weapons
- [ ] Other-Document Details in Notes
- [ ] Unknown

9. Reported financial problems of Consumer - Document Details in Notes.

- [ ] None/Not reported
- [ ] Depleted bank account with no reason
- [ ] Mismanagement of funds (ie. unpaid bills, utility shut-offs)
- [ ] Missing assets (ie. checks, cash, personal property)
- [ ] Unexpected change of name on accounts
- [ ] Other unusual financial arrangements or relationships
- [ ] Unknown

10. Does the Consumer have assistance with legal/financial concerns?

- [ ] Yes
- [ ] No
- [ ] Unknown

11. If response to 2.A.10 is "Yes," check all appropriate options from list below.

- [ ] Guardian
- [ ] Informal Representative
- [ ] Lawyer
- [ ] Power of Attorney (Healthcare)
- [ ] Power of Attorney (Durable)
- [ ] Representative Payee

12. What is the name of the Alleged Perpetrator (AP)? (Document if N/A or Unknown)

_____

13. Does the Alleged Perpetrator currently have access to the Consumer/Consumer assets?

- [ ] Yes
- [ ] No
- [ ] Unknown

14. Where is the Consumer currently located?

_____

3. REPORTER'S DATA

3.A. REPORTER'S INFORMATION

1. REPORTER'S First and Last Name

_____

2. REPORTER'S Phone Number

_____

3. Is this a MANDATED Report?

- ☐ Yes-Skip to 3.B
- ☐ No

4. Type of VOLUNTARY Reporter

- ☐ Alleged Perpetrator (AP)
- ☐ Area Agency on Aging (AAA)
- ☐ Anonymous
- ☐ Assisted Living Facility (AL)
- ☐ Consumer
- ☐ Domiciliary Care Home (DC)
- ☐ Family Member
- ☐ General Public
- ☐ Home Health Care Agency
- ☐ Hospital
- ☐ Law Enforcement Agency
- ☐ LTC Ombudsman
- ☐ Nursing Facility
- ☐ Personal Care Home (PC)
- ☐ Social Service
- ☐ Other-Document Details in Notes

3.B. MANDATORY REPORTERS (If report is voluntary, skip to 4.A)

1. NAME of the Organization/Facility- Mandatory Facilities CANNOT be Anonymous.

_____

2. Type of MANDATORY Reporter

- ☐ Adult Training Facility/Vocational Program
- ☐ Birth Center (BC)-DOH
- ☐ Assisted Living Facility (AL)
- ☐ Community Homes for Individuals with ID - DPW
- ☐ Community Residential Rehabilitation Services (CRRS)-DPW
- ☐ Domiciliary Care Home (DC)
- ☐ Hospice-DOH
- ☐ Hospital LTC-DOH
- ☐ Home Care Agency-DOH
- ☐ Home Care Registry-DOH
- ☐ ICF/ID-DPW
- ☐ In-Home Direct Service Worker
- ☐ Licensed Home Health Care (HH)-DOH
- ☐ Long Term Structured Residence (LTSR)-DPW
- ☐ Nursing Home-DOH
- ☐ Older Adult Daily Living Center (OADLC)
- ☐ Other Public Funded Entity (Licensed or Unlicensed) - Document Details in Notes
- ☐ Personal Care Home (PCH)-DPW
- ☐ Residential Treatment Facility
- ☐ State Mental Hospital-DPW

3. Type of abuse reported

- ☐ Sexual abuse
- ☐ Serious bodily injury (risk of death, permanent disfigurement, loss/impairment)
- ☐ Serious physical injury (causes severe pain, impairs physical functioning)
- ☐ Suspicious death
- ☐ Abuse not listed above-Document Details in Notes

3.C. MANDATORY REPORTS (Sexual Abuse, Serious Physical Injury, Serious Bodily Injury or Suspicious Death)

1. Was the mandatory reporter advised of additional reporting requirements to the appropriate State Agency and Law Enforcement?

- ☐ Yes
- ☐ No (Not one of the four serious, skip to 3.C.4)

2. Date the PS Agency reminded the organization/facility of the additional reporting requirements to the appropriate State Agency and Law Enforcement:

_____/_____/_____

3. Time the PS Agency reminded the organization/facility of the additional reporting requirements to the Appropriate State Agency and Law Enforcement

_____

4. When was the mandatory written report from the facility received by the appropriate PS Agency/Entity?

- ☐ Within 48 hours
- ☐ More than 48 hours
- ☐ Not received

5. Did the PS Agency forward the facility's mandatory written report to the appropriate State Agency?

- ☐ Yes
- ☐ No

4. REPORT OF NEED SUMMARY

4.A. REPORT OF NEED SUMMARY

1. What is the Category assigned to the Report of Need at intake?

- ☐ Emergency-Immediately refer to PS
- ☐ Priority-Immediately refer to PS
- ☐ Non-priority-Normal Business
- ☐ No need for PS (complete 4.A.2)
- ☐ Referred to another entity-include date/time and person receiving RON in Notes.

2. Why categorized as No Need for Protective Services? Document Details in Notes

- ☐ Is not in the jurisdiction of PA (OAPSA only)
- ☐ Is not a resident of PA (APS only)
- ☐ Under age 60 (OAPSA only)
- ☐ Under age 18 or over age 59 (APS only)
- ☐ Able to perform or obtain services on their own (OAPSA only)
- ☐ Able to obtain PS without the assistance of another person (APS)
- ☐ No imminent risk to person or property (OAPSA or APS)
- ☐ Has a responsible caretaker (OAPSA only)
- ☐ No physical/mental impairment limiting 1 or more major life activity (APS only)

4.B. RON CONFIRMATION (Completed by PS Worker or Supervisor)

1. Date Report of Need was received by Protective Service Worker

_____/_____/_____

2. Time Report of Need was received by Protective Service Worker

_____

3. Was the Intake Report of Need Category confirmed? Document who confirmed or changed the category in Notes.

- ☐ No
- ☐ Yes-Skip to 4.B.5

4. If the Category assigned at intake to this Report of Need was changed, enter the appropriate Category here.

- ☐ Emergency-Immediately refer to PS
- ☐ Priority-Immediately refer to PS
- ☐ Non-Priority-Normal Business
- ☐ No need for PS-Explain in Notes
- ☐ Referred to another entity

5. Based on review of the RON, what organizations/agencies were notified of the RON? Check all that apply. Document in the Notes the dates and individual names contacted for each choice below.

- ☐ Coroner
- ☐ Department of Aging (PDA)
- ☐ Department of Health (DOH)
- ☐ Department of Public Welfare (DPW)
- ☐ Law Enforcement - At time of RON - (i.e. NN due to consumer death)
- ☐ MH/DD
- ☐ Ombudsman
- ☐ Other-Document Details in Notes
- ☐ None-Document Details in Notes

6. If referred to a different entity, document the entity, county name, and name of individual receiving report.

_____

5. SIGNATURES

5.A. SIGNATURES, TITLES, & DATES FOR REPORT OF NEED

1. Signature & Title of Intake Worker

_____

2. Date Intake Worker Completed RON

_____/_____/_____

3. Signature & Title of Caseworker Reviewing and/or Investigating

_____

4. Date Caseworker and/or Investigator Received the RON

_____/_____/_____

5. Signature & Title of Supervisor

_____

6. Date Supervisor Reviewed and Approved the Receipt of the RON

_____/_____/_____

7. Signature and Title of Director

_____

8. Date Director Reviewed and Approved the Receipt of the RON and Assignment

_____/_____/_____

Title : _____ Date

Title : _____ Date