



**Reporting of Suspected Abuse:
Child, Dependent Adult or Elder, Domestic**

APPROVED:  
EMS Medical Director EMS Director

1. Purpose
 - 1.1. To describe reporting requirements for prehospital personnel when incidents of child, elder or dependent adult, or domestic violence is reported or reasonably suspected.
2. Definitions
 - 2.1. A child is defined as anyone under the age of 18.
 - 2.2. An elder is defined as any person 65 years of age or older.
 - 2.3. A dependent adult is anyone between 18 and 64 years of age who has physical or mental limitations which 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 those whose physical or mental abilities have diminished due to age.
 - 2.4. Abuse is defined as evidence of physical or emotional abuse, neglect may be defined as intimidation, cruel punishment, fiduciary (financial) abuse, abandonment, isolation or treatment resulting in physical harm or pain or mental suffering or the deprivation by a care custodian of goods and services which are necessary to avoid physical harm or mental suffering.
 - 2.5. Reasonable suspicion is defined as information known to the EMS provider which, drawing on his/her training and experience, would lead another EMS provider in the same situation to suspect that the injury or condition of the patient was the result of a violent act or neglect.
3. Child Abuse or Neglect: When EMS personnel are faced with situations involving known or suspected abuse or neglect of a child, EMS personnel are required to do all of the following:
 - 3.1. Make a reasonable effort to transport the child to a hospital and notify the receiving hospital of the suspected abuse or neglect.
 - 3.2. Notify the appropriate law enforcement agency immediately if the parents are resistant to transporting the child to the hospital.
 - 3.3. Document observations and findings on the patient care report.
 - 3.4. Contact the San Mateo County Children and Family Services (CFS) or law enforcement as soon as possible and no longer than 24 hours after patient care is completed.
 - 3.5. File a written report with CFS within 2 working days of the encounter.

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3.5.1. To report child abuse call: 650-802-7922

- 3.5.2. A written and verbal report of suspected abuse shall be filed by all responding agencies. In the case of multiple individuals from the same agency, a single individual may be designated to file the report.
- 3.6. If there is physical or environmental evidence of abuse, the appropriate law enforcement agency should be contacted to obtain photographic evidence as soon as possible. Patient care or transport should not be delayed to obtain photographs. Notify the law enforcement agency of the intended receiving hospital.
4. Elder and Dependent Adult Abuse or Neglect: When faced with situations involving known or suspected abuse or neglect of an elder or dependent adult EMS personnel are required to:
- 4.1. Make a reasonable effort to transport the elder or dependent adult to the hospital and notify the receiving hospital of the suspected abuse or neglect.
- 4.2. Notify the appropriate law enforcement agency immediately if the care taker is resistant to transporting the patient to the hospital
- 4.3. Document observations and findings on the patient care report
- 4.4. Contact the Teamwork Insuring Elder Support (TIES) line for all instances of abuse or neglect on a 24/7 basis as soon as possible and no later than 24 hours after the event. Call **1-800-675-8437**
- 4.4.1. For reporting concerns related to a licensed care facility the San Mateo County Ombudsman may be contacted during business hours: **650-349-7008**. After hours contact the TIES line.
- 4.5. If there is physical or environmental evidence of abuse the appropriate law enforcement agency should be contacted to obtain photographic evidence as soon as possible. Patient care or transport should not be delayed to obtain photographs. Notify the law enforcement agency of the intended receiving hospital.
5. Domestic Violence: In cases of suspected domestic violence the EMS provider should:
- 5.1. Make every attempt to transport the patient to the hospital
- 5.2. If the patient refuses transportation report the situation to the appropriate law enforcement agency.
- 5.3. Document your findings on the patient care record
- 5.4. Notify the receiving hospital of your suspicions on arrival to the hospital
If there is physical or environmental evidence of abuse the appropriate law enforcement agency should be contacted to obtain photographic evidence as soon as possible. Patient care or transport should not be delayed to obtain photographs. Notify the law enforcement agency of the intended receiving hospital.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

**CONFIDENTIAL REPORT -
NOT SUBJECT TO PUBLIC DISCLOSURE**

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

COUNTY APS/OMBUDSMAN CASE NUMBER _____ LAW ENFORCEMENT CASE/FILE NUMBER _____

RECEIVING AGENCY USE ONLY

A. VICTIM [As applicable under Welfare and Institutions Code (WIC) 15638 (a)] CHECK THIS BOX IF VICTIM CONSENTS TO DISCLOSURE OF INFORMATION (Ombudsman use only)

*NAME (LAST NAME FIRST)	*AGE	DATE OF BIRTH	SSN	SEX <input type="checkbox"/> M <input type="checkbox"/> F	ETHNICITY	LANGUAGE (✓ CHECK ONE) <input type="checkbox"/> NON-VERBAL <input type="checkbox"/> ENGLISH <input type="checkbox"/> OTHER (SPECIFY)
*ADDRESS (IF FACILITY, INCLUDE NAME)			*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

***B. REPORTING PARTY:** Check Appropriate Box if Reporting Party Waives Confidentiality: ALL All but victim All but Perpetrator

*NAME (PRINT)	SIGNATURE	OCCUPATION	AGENCY
RELATION TO VICTIM/HOW KNOWS OF ABUSE	WHERE TO CONTACT (STREET)	(CITY)	(ZIP CODE) TELEPHONE ()

C. INCIDENT INFORMATION - Address where Incident Occurred:

*DATE/TIME OF INCIDENT(S)	PLACE OF INCIDENT (✓ CHECK ONE) <input type="checkbox"/> OWN HOME <input type="checkbox"/> COMMUNITY CARE FACILITY <input type="checkbox"/> HOSPITAL/ACUTE CARE HOSPITAL <input type="checkbox"/> HOME OF ANOTHER <input type="checkbox"/> NURSING FACILITY/SWING BED <input type="checkbox"/> OTHER (Specify)
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***D. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).**

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63) a. PHYSICAL <input type="checkbox"/> ASSAULT/BATTERY <input type="checkbox"/> CONSTRAINT OR DEPRIVATION <input type="checkbox"/> SEXUAL ASSAULT <input type="checkbox"/> CHEMICAL RESTRAINT <input type="checkbox"/> OVER OR UNDER MEDICATION b. <input type="checkbox"/> NEGLIGENCE <input type="checkbox"/> FINANCIAL <input type="checkbox"/> ABANDONMENT <input type="checkbox"/> ISOLATION t. <input type="checkbox"/> ABDUCTION g. <input type="checkbox"/> OTHER (Non-Mandated: e.g., deprivation of goods and services; psychological/mental)	2. SELF-NEGLECT (WIC 15610.57(b)(5)) a. <input type="checkbox"/> PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter) b. <input type="checkbox"/> MEDICAL CARE (e.g., physical and mental health needs) c. <input type="checkbox"/> HEALTH and SAFETY HAZARDS d. <input type="checkbox"/> MALNUTRITION/DEHYDRATION e. <input type="checkbox"/> OTHER (Non-Mandated e.g., financial)
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ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) NO PHYSICAL INJURY MINOR MEDICAL CARE HOSPITALIZATION CARE PROVIDER REQUIRED
 DEATH MENTAL SUFFERING OTHER (SPECIFY) UNKNOWN

***E. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (E.G., ANIMALS, WEAPONS, COMMUNICABLE DISEASES, ETC.).** CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

F. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. (If unknown, list contact person).

*NAME	IF CONTACT PERSON ONLY ✓ CHECK <input type="checkbox"/>	*RELATIONSHIP
*ADDRESS	*CITY	*ZIP CODE TELEPHONE ()

G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. (e.g., family, significant others, neighbors, medical providers and agencies involved, etc.)

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
		()	

H. SUSPECTED ABUSER ✓ Check if Self-Neglect

NAME OF SUSPECTED ABUSER	<input type="checkbox"/> CARE CUSTODIAN (type) _____	<input type="checkbox"/> PARENT <input type="checkbox"/> SON/DAUGHTER <input type="checkbox"/> OTHER _____
	<input type="checkbox"/> HEALTH PRACTITIONER (type) _____	<input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER RELATION _____
ADDRESS	*ZIP CODE TELEPHONE ()	SEX <input type="checkbox"/> M <input type="checkbox"/> F ETHNICITY AGE D.O.B. HEIGHT WEIGHT EYES HAIR

I. TELEPHONE REPORT MADE TO: APS Law Enforcement Ombudsman Calif. Dept. of Mental Health Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	*TELEPHONE ()	DATE/TIME
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J. WRITTEN REPORT Mailed or Faxed (DO NOT FAX REPORT TO CDSS) FAX to agency to which telephone report was made.

AGENCY NAME	ADDRESS OR FAX #	DATE MAILED OR FAXED
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K. RECEIVING AGENCY USE ONLY Telephone Report Written Report

1. Report Received by: _____ Date/Time: _____

2. Assigned Immediate Response Ten-day response No initial face-to-face required Not APS
 Approved by: _____ Assigned to (optional): _____

3. Cross-Reported to: CDHS, Licensing & Cert.; CDSS-OCL; CDA Ombudsman; Bureau of Medi-Cal Fraud & Elder Abuse; Mental Health; Law Enforcement; Professional Board; Developmental Services; APS; Other (Specify) _____ Date of Cross-Report: _____

SOC 341 (8/03)

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SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

CASE NAME: _____
CASE NUMBER: _____

PLEASE PRINT OR TYPE

A. REPORTING PARTY	NAME OF MANDATED REPORTER		TITLE		MANDATED REPORTER CATEGORY					
	REPORTERS BUSINESS/AGENCY NAME AND ADDRESS			Street	City	Zip	DID MANDATED REPORTER WITNESS THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	REPORTERS TELEPHONE (DAYTIME) ()		SIGNATURE		TODAY'S DATE					
B. REPORT NOTIFICATION	<input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> COUNTY PROBATION		AGENCY							
	<input type="checkbox"/> COUNTY WELFARE / OPS (Child Protective Services)		ADDRESS		Street	City	Zip	DATE/TIME OF PHONE CALL		
	OFFICIAL CONTACTED - TITLE				TELEPHONE ()					
C. VICTIM One report per victim	NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY			
	ADDRESS			Street	City	Zip	TELEPHONE ()			
	PRESENT LOCATION OF VICTIM				SCHOOL	CLASS	GRADE			
	PHYSICALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEVELOPMENTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME					
	IN FOSTER CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: <input type="checkbox"/> DAY CARE <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> FOSTER FAMILY HOME <input type="checkbox"/> FAMILY FRIEND <input type="checkbox"/> GROUP HOME OR INSTITUTION <input type="checkbox"/> RELATIVE'S HOME			TYPE OF ABUSE (CHECK ONE OR MORE) <input type="checkbox"/> PHYSICAL <input type="checkbox"/> MENTAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> NEGLECT <input type="checkbox"/> OTHER (SPECIFY)					
	RELATIONSHIP TO SUSPECT			PHOTOS TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK				
D. INVOLVED PARTIES	VICTIMS									
	1. NAME		BIRTHDATE	SEX	ETHNICITY	3. NAME		BIRTHDATE	SEX	ETHNICITY
	2. _____		_____		4. _____		_____		_____	
	PARENTS/GUARDIANS									
	NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY			
	ADDRESS			Street	City	Zip	HOME PHONE ()	BUSINESS PHONE ()		
	NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY			
	ADDRESS			Street	City	Zip	HOME PHONE ()	BUSINESS PHONE ()		
	SUSPECT									
	SUSPECT'S NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY			
ADDRESS			Street	City	Zip	TELEPHONE ()				
OTHER RELEVANT INFORMATION										
E. INCIDENT INFORMATION	IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX: <input type="checkbox"/>				IF MULTIPLE VICTIMS, INDICATE NUMBER: _____					
	DATE / TIME OF INCIDENT		PLACE OF INCIDENT							
	NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)									

DEFINITIONS AND INSTRUCTIONS ON REVERSE

SS 8572 (Rev. 12/02)

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

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DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

All Penal Code (PC) references are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: <http://www.leginfo.ca.gov/calaw.html> (specify "Penal Code" and search for Sections 11164-11174.3). A mandated reporter must complete and submit the form SS 8572 even if some of the requested information is not known. (PC Section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

- Mandated child abuse reporters include all those individuals and entities listed in PC Section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

- Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC Section 11165.9.)

III. REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof *within 36 hours* of receiving the information concerning the incident. (PC Section 11166(a).)
- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

IV. INSTRUCTIONS

- **SECTION A - REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC Section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (Continued)

- **SECTION B - REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.
- **SECTION C - VICTIM (One Report per Victim):** Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes-no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes-no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.
- **SECTION D - INVOLVED PARTIES:** Enter the requested information for: Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- **SECTION E - INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

- **Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
- **Designated Agency:** *Within 36 hours* of receipt of Form SS 8572, send **white copy** to police or sheriff's department, **blue copy** to county welfare or probation department, and **green copy** to district attorney's office.

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian