RON 12-23-2013

REPOR	TER'S DETAILS			Separated
				Widowed
1.A. CO	DNSUMER'S INFORMATION			Other-Document Details in Notes
1.	Date RON Received			Unavailable/Unknown
		5.	Gei	 nder
	/			Female
2.	Time RON Received			
				Male
		6.	500	cial Security Number (SSN) (Optional)
3.	Date(s) of the incident(s)			⁻
		7.	Eth	nnicity
				Hispanic or Latino
4.	LAST Name			Not Hispanic or Latino
				Unknown
		8.	Ra	ce(s)
5.	FIRST Name			American Indian/Native Alaskan
				Asian
				Black/African American
6.	MIDDLE Initial		┢	Native Hawaiian/Other Pacific Islander
				Non-Minority (White, Non-Hispanic)
				White-Hispanic
7.	Name SUFFIX (if applicable)			Other-Document in Notes
				Unavailable
1.B. CO	DNSUMER'S DEMOGRAPHIC DATA	9. cate ren	Cui egor t, or	」 rrent Living Arrangement (Include in the "Lives Alor y, Consumers who live in AL, Dom Care, and PCH, pa have no roommate.)
1	What type of communication excitance will be needed to			Lives Alone
comr	What type of communication assistance will be needed to municate with consumer?		-	Lives Alone Lives with Spouse Only
	Language			Lives with Spouse Only Lives with Child(ren) but not Spouse
	Language and Mechanical			Lives with Other Family Member(s)
	Mechanical			Other-Document Details in Notes
	American Sign Language (ASL)			Don't Know
	None/Not Reported			DOILT KHOW
2.	Primary Language			
	American Sign Language			
	English			
	Russian			
	Spanish			
i	Other-Document in Notes			
3. age i	Date of Birth (DOB) (If unknown, document an estimated in Notes)			
3. age i	Date of Birth (DOB) (If unknown, document an estimated			
age i	Date of Birth (DOB) (If unknown, document an estimated in Notes)			
age i	Date of Birth (DOB) (If unknown, document an estimated in Notes)// Marital Status			
age i	Date of Birth (DOB) (If unknown, document an estimated in Notes)			

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

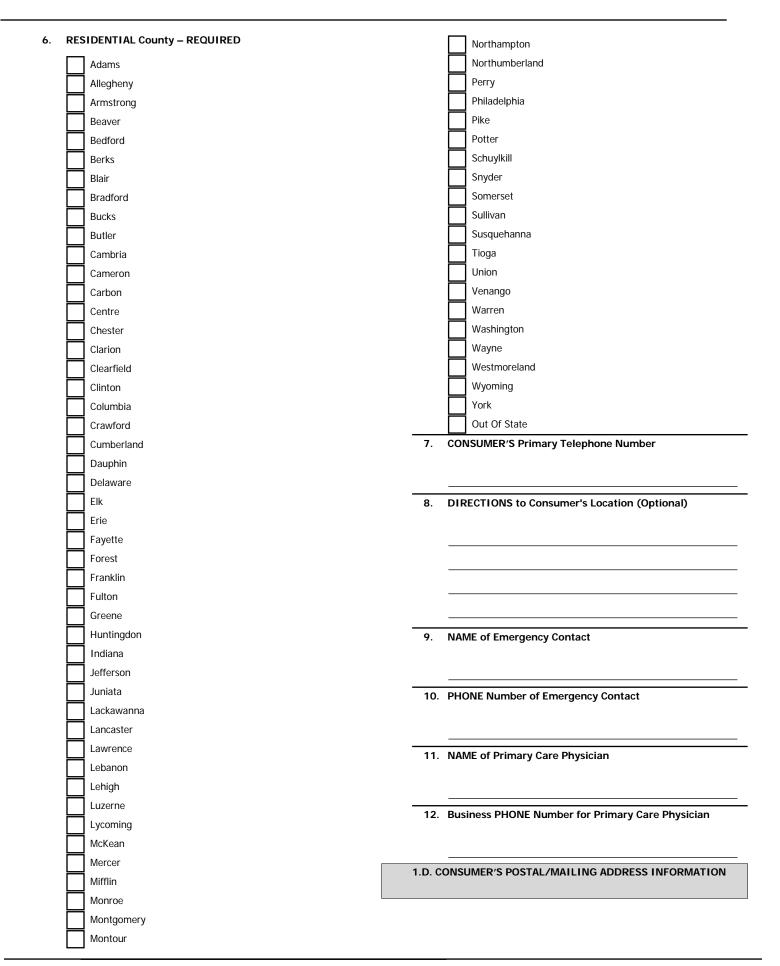
1. Name of facility, if residing in a facility. (If not residing in a facility, document as N/A.)

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.)



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

2. POSTAL Address Second Line (if needed)

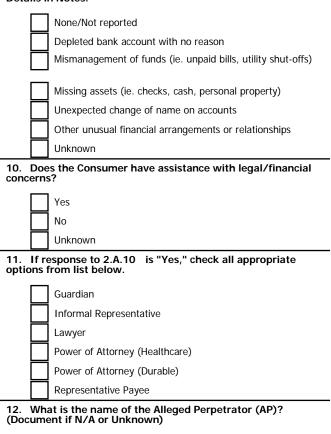
3. POSTAL City or Town

4. POSTAL State

5. POSTAL Zip Code

2. REPORTER'S OBSERVATIONS	Medical Diagnoses Leading to Physical Disability
2.A. CONSUMER'S CURRENT SITUATION	Physical Disability
	Speech Impairment
1. Identify ALL ALLEGATIONS made by the reporter. Document ALL Details provided regarding EACH ALLEGATION	Other-Document Details in Notes
in the Notes section.	Unknown
Physical abuse	5. Indicate the types of substance abuse:
Emotional abuse	None/Not reported
Self neglect	Alcohol
Caretaker/Caregiver neglect	Illegal drugs
Exploitation	Misusing prescribed medications
Abandonment	Other-Document Details in Notes
Sexual abuse	6. Reported emotional and mental conditions of
2. Is the consumer in a life threatening situation?	Consumer - Document all Details in Notes.
	None/Not Reported
Yes	Confusion (ie. memory loss, wandering)
	Disoriented (ie. to person, place, or time)
Unknown	Feels threatened or intimidated
 Reported physical and health conditions of consumer - Document ALL Details in Notes. 	Hallucinations (ie. hearing voices, seeing non-existent objects or people)
None/Not reported	Recent suicidal talk/actions/thoughts
Amputation	Unable to communicate and/or comprehend
Arthritis	Other-Document Details in Notes
Functional limitations	Unknown
Medication mismanagement (ie. undermedicated, substance abuse)	7. Reported problems with the physical environment of Consumer - Document all Details in Notes.
Physical trauma (ie. bruises, cuts, burns, signs of sexual abuse)	None/Not reported
Poor personal hygiene (ie. dirty, odorous, poor dental health)	Architectural barriers (ie. inaccessible, bathroom, stairway)
Poor nutritional status (ie. malnourished, dehydrated, weight loss)	Garbage/trash accumulation
Recent hospitalizations (ie. hospitalized in last 30 days)	Inadequate utilities (ie. heat, plumbing)
Unmet personal needs (ie. lack of false teeth, eyeglasses,	In need of repair
L hearing aid)	Insect/pest problem(s) Pet/animal problem(s) (ie. overpopulation, inadequate care)
Untreated medical condition (ie. ulcerations, bedsores)	
Other-Document Details in Notes	Safety hazard(s) (ie. fire danger, leaky roof)
Unknown	Other-Document Details in Notes
4. Type of disability(ies) reported:	Unknown
None/Not Reported	8. Note any dangers - Document Details in Notes.
ALS (Lou Gehrig's)	None/Not reported
Alzheimer's/Dementia	History of Violent Behavior in Home
Autism Spectrum Disorder	Gang Activity
Blind/Visually Impaired	Neighborhood Dangers
Brain Injury (Traumatic/Acquired)	Known Drug Activity
Chemical Dependency, including Alcohol and Substance Abuse	Pets
	Weapons
	Other-Document Details in Notes
Deaf/Hearing Impaired	Unknown
Epilepsy	
Mental Illness	

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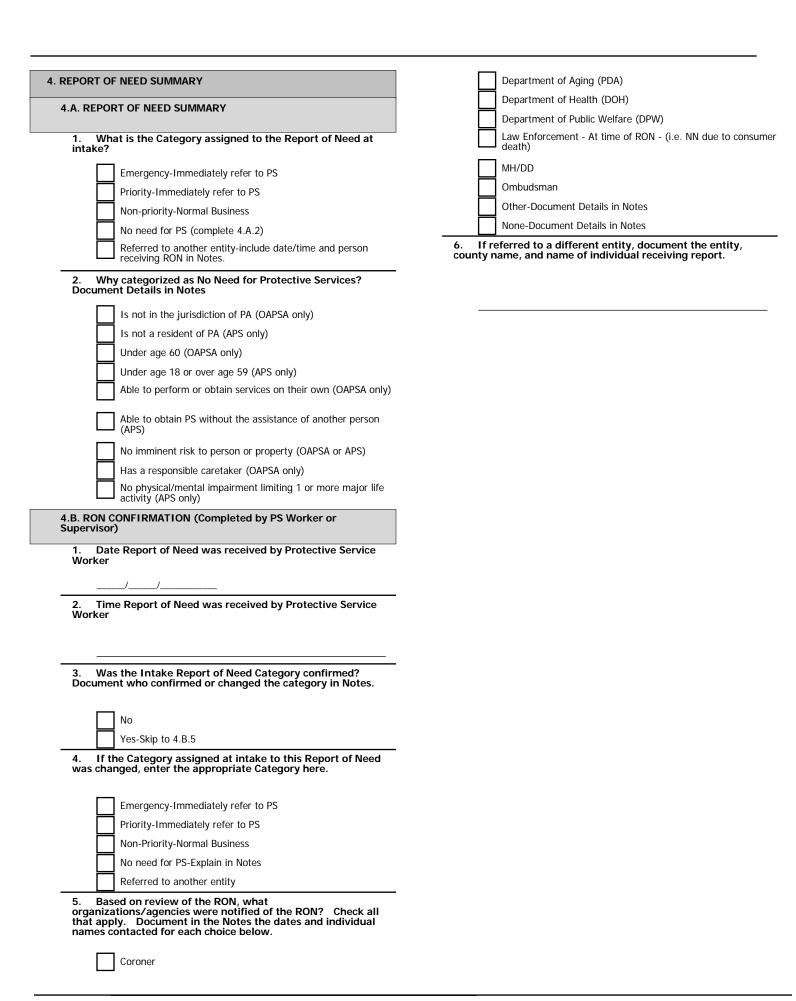


13. Does the Alleged Perpetrator currently have access to the Consumer/Consumer assets?



14. Where is the Consumer currently located?

3. REPORTER'S DATA	In-Home Direct Service Worker
3.A. REPORTER'S INFORMATION	Licensed Home Health Care (HH)-DOH
	Long Term Structured Residence (LTSR)-DPW
1. REPORTER'S First and Last Name	Nursing Home-DOH
	Older Adult Daily Living Center (OADLC)
	Other Public Funded Entity (Licensed or Unlicensed) - Document Details in Notes
2. REPORTER'S Phone Number	Personal Care Home (PCH)-DPW
	Residential Treatment Facility
	State Mental Hospital-DPW
3. Is this a MANDATED Report?	3. Type of abuse reported
Yes-Skip to 3.B	Sexual abuse
No	Serious bodily injury (risk of death, permanent disfigurement,
4. Type of VOLUNTARY Reporter	loss/impairment)
Alleged Perpetrator (AP)	Serious physical injury (causes severe pain, impairs physical functioning)
Area Agency on Aging (AAA)	Suspicious death
Anonymous	Abuse not listed above-Document Details in Notes
Assisted Living Facility (AL)	3.C. MANDATORY REPORTS (Sexual Abuse, Serious Physical
Consumer	Injury, Serious Bodily Injury or Suspicious Death)
Domiciliary Care Home (DC)	1. Was the mandatory reporter advised of additional
Family Member	reporting requirements to the appropriate State Agency and Law Enforcement?
General Public	Yes
Home Health Care Agency	No (Not one of the four serious, skip to 3.C.4)
Hospital	
Law Enforcement Agency	2. Date the PS Agency reminded the organization/facility of the additional reporting requirements to the appropriate
LTC Ombudsman	State Agency and Law Enforcement:
Nursing Facility	
Personal Care Home (PC)	
Social Service	3. Time the PS Agency reminded the organization/facility of the additional reporting requirements to the Appropriate
Other-Document Details in Notes	State Agency and Law Enforcement
3.B. MANDATORY REPORTERS (If report is voluntary, skip to 4.A)	
1. NAME of the Organization/Facility- Mandatory Facilities	
CANNOT be Anonymous.	4. When was the mandatory written report from the facility
	received by the appropriate PS Agency/Entity?
	Within 48 hours
2. Type of MANDATORY Reporter	More than 48 hours
Adult Training Facility/Vocational Program	Not received
Birth Center (BC)-DOH	5. Did the PS Agency forward the facility's mandatory
Assisted Living Facility (AL)	written report to the appropriate State Agency?
Community Homes for Individuals with ID - DPW	Yes
Community Residential Rehabilitation Services (CRRS)-DPW	No
Domiciliary Care Home (DC)	
Hospice-DOH	
Hospital LTC-DOH	
Home Care Agency-DOH	
Home Care Registry-DOH	
ICF/ID-DPW	



5. SIGNATURES

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

1. Signature & Title of Intake Worker

Date Intake Worker Completed RON 2.

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

Date Caseworker and/or Investigator Received the RON 4.

/ Signature & Title of Supervisor 5.

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

/

Signature and Title of Director 7.

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

_/__ _

Title :

Title :

Date

Date