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|  | **Tennessee Department of Human Services**  **Grants Referral Form** |

**DISCLAIMER:** The alleged perpetrator information and allegations provided in this document are confidential and must not be shared with anyone except APS staff. The information provided is only an allegation, and should not be construed as a finding of fact or substantiation against the alleged perpetrator.

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| **Referral Information** | | |
| Date Referred to Agency: | Name of Contract Agency: | |
| Referred by: | Phone Number: | Email address: |
| TNAPS ID: | Does the client know the referral is being made? | |

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| **Case Information** | | | | | |
| Homemaker | | Adult Day Services | | Specific Assistance | |
| CREST | | CREVAA | |  | |
| 1. Alleged Perpetrator Name: | | | | | |
| Allegations at Intake: | Abuse | | Neglect | | Exploitation |
| 1. Alleged Perpetrator Name: | | | | | |
| Allegations at Intake: | Abuse | | Neglect | | Exploitation |
| Notes: | | | | | |

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| **Client Information** | | | | | | |
| Client Name: |  | Phone Number | | | | |
| Street Address | | | City | | County Choose an item. | Zip |
| Directions to home: | | | | | | |
| Date of Birth: | | | | Social Security Number: | | |
| Gender: | | | | Relationship Status | | |
| Other Support (i.e., family/friends in home, hospice, CHOICES, etc.): | | | | | | |

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| **Primary Vulnerabilities** | | | | |
| Amputee | Bedfast | Bedsores | Bi-Polar | Bladder/Bowel Incontinence |
| Blindness | Clinical Depression | Combative | Deafness | Dementia/Memory Loss |
| Diabetic | Drug/alcohol Addiction | Fall Risk | Feeding Assistance | Hepatitis A |
| Hospice | Intellectual/Developmental Disability | Oxygen Dependent | Parkinson’s | Schizophrenic |
| Seizures | Speech Problems | Traumatic Brain Injury | Wheelchair | Walker |
| Other vulnerabilities: | | | | |
| History of broken bones: | | | | |
| Allergies: | | | | |
| Ability to complete ADLs | | | | |
| Describe any limitations (physical, mental, cognitive, etc.) | | | | |

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| **Demographic Information** | | | |
| Race | | Ethnicity | |
| Is language interpretation needed? | | Language: | |
| Proof of citizenship in TNAPS | | Type of documentation provided: | |
| Special Populations (Choose all that apply): | | | |
| Deaf/Hard of Hearing | Homeless | | Immigrants/Refugees/Asylum Seekers |
| LGBTQ | Veterans | | |
| Cognitive Disability | Physical Disability | | Mental Illness |
| Limited English Proficiency | Elderly | | |

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| **Emergency Contact** | | |
| Name: | Relationship to client: | |
| Primary Phone: | Secondary Phone: | |
| Notes: | | No Emergency Contact |

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| **Power of Attorney (POA)** | | | | |
| Financial: |  | Name: | Relationship: | Telephone: |
| Medical: |  | Name: | Relationship: | Telephone: |

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| **Specific Assistance** | | | | | | | | |
| Client Circumstances | | Explanation of Client Circumstances and Need | | | | | | |
| Stability | | How will assistance lead to client stability/independence? | | | | | | |
| What type of Specific Assistance are you requesting? (Choose a max of three (3) options) | | | | | | | | |
| Choose a type. | | | | Choose a type. | | | Choose a type. | |
| Other |  | | | | | | | |
| Which community resources were pursued first? | | | | | | | | |
| Church | | | CSBG | | Food Bank | LIHEAP | | Meals on Wheels |
| SNAP | | | Utility Company | | Other | | | |
| Describe the client’s specific service needs: i.e. quantity and sizes of clothing, type of bill, account numbers, name of landlord, dollar amount requested, etc. | | | | | | | | |

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| **Personal Support** | | | | | | | | | |
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| Other: | | Other: | | | | | | Other: | |
| **Home Environment** | | | | | | | | | | |
| Housing: | | | Cleanliness | | | Overcrowded (Inhabitants): | | | | |
| If available, landlord name and phone: | | | | | | | | | |
| Pets | Type: | | | Qty | Indoor | | Outdoor | | Aggressive |
| Notes: | | | | | | | | | |
| Unsecured weapons? | | | Type: | | | | | Location: | |
| Pest Control needed? | | | Type: | | | | | Location: | |
| Exposed body fluids | | | Type: | | | | | Location: | |
| Unsafe Physical Environment: | | | | | | | | | |

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| **Please give a detailed narrative for the referral and the client’s needs.** |
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| **Client’s plan to meet the need in the future (Long-Term Plan or Safety Plan)** |
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| **(CREVAA Only)** What crime(s) were perpetrated against the victim? | |
|  | Burglary |
|  | DUI/DWI |
|  | Elder Abuse or Neglect (includes Financial Exploitation) |
|  | Identity Theft/Fraud/Financial Crime |
|  | Robbery |
|  | Stalking/Harassment |
|  | Other Vehicular Victimization (e.g. Hit and Run) |
| Brief description of alleged crime/alleged perpetrator: | |
| Date of alleged crime: | |