



The Commonwealth of Massachusetts Disabled Persons Protection Commission

M.G.L. c. 19C Reporting Form

When completed, this form should be mailed or FAXED to:

Intake Unit, DPPC, 300 Granite Street, Suite 404, Braintree MA 02184 * FAX: (617) 727-6469

Reporter:		Alleged Victim:	
Name:		Name:	
Address:		Address:	
Daytime telephone: ()		Telephone: ()	
() Mandated		Sex: () Male () Female	
() Non-Mandated		DOB:	
Relationship to Alleged Victim:		Age:	
		Marital Status:	
Alleged Abuser: (Alleged Victim's Caretaker)		Disability: (check as apply)	
Name(s):		() Mental Retardation () Mental Illness	
Home address:		() Mobility () Head Injury	
Relationship to victim:		() Visual () Deaf / Hard of Hearing	
Soc. Security #: DOB:		() Cerebral Palsy () Multiple Sclerosis	
Telephone: ()		() Seizures () Other (Specify: _____)	
Client's Guardian(s): (If any)		Communication Needs:	
Name(s):		() TTY () Sign Interpreter () Other (Specify: _____)	
Address:		Currently Served By:	
Relationship to Alleged Victim:		() Dept. of Mental Health () Mass Comm./Blind	
Telephone: ()		() Dept. of Mental Retardation () Mass. Comm./Deaf/HH	
		() Mass. Rehab. Comm. () Unknown	
		() Dept. of Correction () Other (Specify: _____)	
		() Dept. of Public Health () None	
Collateral contacts or notifications: (Please list, including telephone numbers.)		Type of Service:	
		() Institutional () Service Coordination	
		() Residential () Foster / Spec. Home Care	
		() Day Program () Respite	
		() Case Management () Other (Specify: _____)	
		Client's Ethnicity:	
		() Caucasian () Hispanic () Asian	
		() African American () Native American	
		() Other (Specify: _____)	
Frequency of Abuse:		Is victim aware of report?	
() Daily () Increasing		() Yes () No	
() Weekly () Decreasing			
() Episodic () Constant		Types of Abuse: (List all which apply)	
() Unknown		() Physical () Omission	
Date of last incident:		() Sexual () Other (Specify: _____)	
		() Emotional	

Please describe alleged abuse on the back side of this form.

***You must file an oral report of suspected abuse; please call 800-426-9009**

Description - Please complete the following sections.

1. In narrative form, please describe the alleged abuse:

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2. Please describe the level of risk to the alleged victim, including his/her current physical and emotional state:

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3. Please list any resulting injuries:

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4. Please list witnesses, if any, including daytime phone numbers:

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**5. Please describe caregiver relationship between the alleged abuser and the alleged victim.
(What assistance, if any, does the alleged abuser provide to the person with the disability?)**

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6. Was an oral report filed with the DPPC Hotline?

- YES (Please note date and time of call: _____)
 NO (If no, please call 800-426-9009 to file an oral report)

7. Is there any risk to the investigator?

- YES If yes, please specify:
 NO

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