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:

Name:

Address:

Daytime telephone: ( )

( ) Mandated

( ) Non-Mandated

Relationship to Alleged Victim:

Alleged Victim:

Name:

Address:

Telephone: ( )

Sex: ( ) Male ( ) Female DOB:

Age: Marital Status:

Disability: (check as apply)

( ) Mental Retardation ( ) Mental Illness

( ) Mobility ( ) Head Injury

( ) Visual ( ) Deaf / Hard of Hearing

( ) Cerebral Palsy ( ) Multiple Sclerosis

( ) Seizures ( ) Other (Specify: _____)

Alleged Abuser: (Alleged Victim's Caretaker)

Name(s):

Home address:

Relationship to victim:

Soc. Security #: DOB:

Telephone: ( )

Communication Needs:

( ) TTY ( ) Sign Interpreter ( ) Other (Specify: _____)

Client's Guardian(s): (If any)

Name(s):

Address:

Relationship to Alleged Victim:

Telephone: ( )

Currently Served By:

( ) Dept. of Mental Health ( ) Mass Comm./Blind

( ) Dept. of Developmental Svcs. ( ) 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:

( ) Daily ( ) Increasing

( ) Weekly ( ) Decreasing

( ) Episodic ( ) Constant

( ) Unknown

Date of last incident:

Is victim aware of report?

( ) Yes ( ) No

Types of Abuse: (List all which apply)

( ) Physical ( ) Omission

( ) 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:

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

3. Please list any resulting injuries:

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

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?)

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