ADULT PROTECTIVE SERVICES MANUAL

ADULT PROTECTIVE SERVICES

FAMILY HOMES FOR ADULTS

AIDS

INTERSTATE

Tennessee Department of Human Services

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EDP#	HS#	Document Name	Stock Order #
700	0055	Adult Protective Services Intake (Electronic) Adult Protective Services Intake (Handwritten) Instructions	Intranet
	0066	Medical Report - Adult Family Home	Intranet
	0069	Report of Physician's Examination for Resident of Family Home for Adults	Intranet
	0070	Application to Provide A Family Home for Adults	Intranet
	0071	Adult Placement Contract	
		Attachment #1 to HS 0071 - Adult Placement Contract	Intranet
1215	0875	Report of Alleged Abuse, Neglect or Exploitation of an Adult Instructions	Intranet
	1143	Financial Information for Adult Family Home Sponsor(s)	Intranet
	1169	Questionnaire on Closed Adult Protective Services Cases Instructions	395-51-00HS1169
3550	1262	Volunteer Enrollment Form	395-51-00003550
	1667	Emergency Information About Adult in Family Home Care	Intranet

EDP#	HS#	Document Name	Stock Order #
	2431	Fire Safety Checklist for Family Homes for Adults	Intranet
1125	2493	Physician's Statement of Need for Court Ordered Protective Services	Intranet
	2621	Body Diagram Chart Instructions	395-51-00HS2621
	2630	Abbreviated Documentation of APS Investigation/Assessment Form Instructions	Intranet
	2638	(Facility) APS Investigative Report/ Assessment Instructions	Intranet
	2750	APS Case Closure Summary Instructions	Intranet
	2751	APS Multi-Disciplinary Team Recommendation	Intranet
	2752	Legal Referral for Actions Pursuant to the Tennessee Adult Protection Act Instructions	Intranet
	2753	Referral to APS Multidisciplinary Case Consultation Team	Intranet
	2754	Adult Protective Services Plan Instructions	Intranet
	2785	APS INPUT Instructions	Intranet
	2832	(FA) Authorization for Release of Information	Intranet
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SECTION 1 - GENERAL INFORMATION

1-01 INTRODUCTION

Tennessee was one of the first states to pass legislation mandating the provision of protective services to adults. General Services were provided to adults in the 1960's. In October, 1971, responsibility for providing services to adults was transferred to the Social Services staff. All services to adults at that time were voluntary.

With increasing concern for the growing older population, legislation was passed in Tennessee in 1974 which mandated that protective services be provided to those 60 years of age or older. This paved the way for the bill passed by the Tennessee General Assembly in 1978 which provided protective services for all mentally or physically dysfunctioning adults in need of such services, regardless of age. In 1980, the Protective Services for Elderly Persons Act (1974) was repealed and the Adult Protection Act (1978) was amended to clearly include the elderly. Amendments in 1986, 1995, 1996, 1999, 2000, 2001, and 2004 have clarified portions of the law and expanded options available in the provision of protective services.

It is now possible for the Tennessee Department of Human Services to provide protective services to all adults in need of such services. Additionally, in some cases when the adult lacks the capacity to consent to such services or when other legal criteria are met, court intervention may be requested. It is also recognized that adult abuse and neglect are social problems which affect the entire community and the community shares in the responsibility to seek solutions and provide protection to dependent, abused or neglected adults.

1-02 PHILOSOPHY

The Department agrees with the philosophy that attainment of the age of majority, i.e., adulthood, is the point at which an individual should have the freedom to determine his/her lifestyle insofar as is possible. This rationale dictates that an adult at risk must be involved in deciding what plans will be made and what actions will be taken to afford him/her the protection which may be needed. The adult client needs to understand the options available to him/her and may need to be assisted in obtaining and understanding this information.

An adult has a right to self-determination, and at the same time an adult has a right under the law to be protected when he/she is unable to protect himself/herself. Out of concern for an individual's personal freedom, it is important for APS to seek the course of action which affords the needed protection while at the same time encroaches the least upon that freedom.

Protective Services is for adults who are in need of protection and who are dependent on this service to some degree for that protection. Although the quality of life is certainly improved by the availability of this service, improving the quality of life is not the sole purpose of the service. The purpose of the service is to prevent abuse, neglect and financial exploitation. APS supports clients and their families in their efforts to protect the client. APS attempts to maintain an adequate level of safety for the adult. The focus of services is necessarily on "adequate" levels of care.

The Department, in an effort to meet its legal mandate, guard against interfering with the rights of adults, and offer at least an adequate level of care and safety for those in need of protection, uses the following basic principles to guide planning in protective services:

(1) To the extent possible, the client participates in making the decision as to the action which should be taken to meet his/her needs.

(2) The client is helped to remain at home or in the community so long as his/her condition warrants it.

(3) The action taken should always be the least restrictive/ intrusive alternative available which will meet the individual's needs.

(4) To the extent possible, families, caregivers and other significant members of the informal support system should be involved in meeting the needs of the adult client.

(5) Legal action is only considered after all possible alternatives to legal action have been explored.

(6) After legal action is taken involving loss of rights of self-direction, they are restored as soon as the adult regains his/her capacity to make such decisions. It is not assumed that the inability of a person to direct his/her affairs is permanent.

1-03 FUNCTIONS OF ADULT PROTECTIVE SERVICES

Protective services for adults includes the following activities:

- receiving reports of adults in need of protective services;
- conducting investigations of reports received and accepted;
- identifying and assessing the individual's situation and service needs through the use of physical, psychological, psychiatric or social evaluations and consultations;
- determining levels of risk and danger;
- counseling with adults at risk or their appropriate representatives;
- assisting in locating or maintaining adequate food, shelter and clothing;
- assisting in obtaining required medical care or mental health services;
- assisting in arranging for conservatorship, commitment or protective placements as needed;
- assisting in locating or arranging for emergency shelter care;
- providing legal intervention, when necessary;
- developing safety plans;
- assisting with transportation necessary in the provision of these service components;
- providing advocacy on behalf of the client or the program.

1-04 AUTHORITY OF THE DEPARTMENT

1-04-01 **Legislative Intent:** T.C.A. 71-6-111

It is the legislative intent that the Department have authority to provide or to arrange for the provision of protective services.

"Protective Services for Elderly Persons" Chapter 730 of the Tennessee Public Acts of 1974 authorized the provision of protective services to adults 60 years of age or older. This chapter was repealed in 1980.

The "Tennessee Adult Protection Act", Chapter 899 of the Tennessee Public Acts of 1978 mandated the provision of protective services for mentally or physically dysfunctioning adults age 18 and over. This chapter was amended in 1980 when the Protective Services for Elderly Persons Act was repealed. In 1986, significant changes were made in the Adult Protection Act. In 1989, amendments were made to the Act and it was retitled "Programs and Services for Abused Persons." The Adult Protection part provides the legal base for the provision of protective services for adults in Tennessee.

The Act was amended in 1995 to expand the legal interventions available to APS. A copy of the current "Programs and Services for Abused Persons" which may also be referred to as the **"Tennessee Adult Protection Act,"** TCA, Title 71 Chapter 6 Part 1 and all Amendments are in Appendix 11-01. **T.C.A. 71-6-101 et. seq**.

1-05 LEGAL DEFINITIONS

1-05-01 **"Protective Services"** means services undertaken by the department with or on behalf of an adult in need of protective services who is being abused, neglected, or exploited. These services may include, but are not limited to, conducting investigations of complaints of possible abuse, neglect, or exploitation to ascertain whether or not the situation and condition of the adult in need of protective services warrants further action; social services aimed at preventing and remedying abuse, neglect, and exploitation; services directed toward seeking legal determination of whether the adult in need of protective services has been abused, neglected, or exploited and procurement of suitable care in or out of his home. T.C.A. 71-6-102(11)

1-05-02 **"Adult"** means a person eighteen (18) years of age or older who, because of mental or physical dysfunctioning or advanced age, is unable to manage his/her own resources, carry out the activities of daily living, or protect himself/herself from neglect, hazardous, or abusive situations without assistance from others; and who has no available, willing, and responsibly able person to assist him/her; and may be in need of protective services. T.C.A. 71-6-102(2)

1-05-03 **"Advanced Age"** means sixty (60) years of age or older. T.C.A. 71-6-102(3)

1-05-04 **"Abuse or Neglect"** means the infliction of physical pain, injury, mental anguish, or the deprivation of services by a caretaker which are necessary to maintain the health and welfare of an adult or a situation in which an adult is

unable to provide or obtain for himself/herself the services which are necessary to maintain his/her health or welfare. Nothing in this act shall be construed to mean a person is abused or neglected or in need of protective services for the sole reason that he/she relies on or is being furnished treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment. Further, nothing in this chapter shall be construed to require or authorize the provision of medical care to any terminally ill person if such person has executed an unrevoked living will in accordance with the provisions of the Tennessee Right to Natural Death Law and if the provisions of such medical care would conflict with the terms of such living will. T.C.A. 71-6-102(1)

1-05-05 **"Exploitation"** means the improper use by a caretaker of funds which have been paid by a governmental agency to an adult or to the caretaker for the use or care of the adult. T.C.A. 71-6-102(7)

1-05-06 **"Sexual abuse"** occurs when an adult is forced, tricked, threatened or otherwise coerced by a person into sexual activity, involuntary exposure to sexually explicit material or language, or sexual contact against his/her will. Sexual abuse also occurs when an adult as defined in this chapter, is unable to give consent to such sexual activities or contact and is engaged in such activities or contact with another person. T.C.A. 71-6-102(12).

1-05-07 **"Caretaker"** means an individual or institution who has the responsibility for the care of the adult as a result of family relationship or who has assumed the responsibility for the care of the adult person voluntarily, by contract or agreement. T.C.A. 71-6-102(5)

1-06 DUTY OF THE DEPARTMENT

Upon receiving a report of abuse, neglect or exploitation of an adult, the Department shall:

1. Notify the appropriate law enforcement agency in all cases in which the report involves abuse, neglect or exploitation of the adult by another person or persons. T.C.A. 71-6-103

2. Notify the appropriate licensing authority when the adult is a resident...of a residential facility...; T.C.A. 71-6-103

3. Initiate an investigation of the complaint; T.C.A. 71-6-103

4. Make a written report of the initial findings and a recommendation for further action; T.C.A. 71-6-103

5. After completing the evaluation, notify the complainant of the Department's determination; T.C.A. 71-6-103

6. Provide protective services when the investigation indicates that such services are necessary. T.C.A. 71-6-103

The above listed duties are discussed in more detail in subsequent sections of this chapter.

1-07 CONFIDENTIALITY OF THE REPORTER AND CASE RECORDS

1-07-01 **Confidentiality of the Reporter** T.C.A. 71-6-118

According to the provisions of the Tennessee Adult Protection Act, the identity of a person who reports abuse, neglect, or exploitation must remain confidential and may not be released unless a court with jurisdiction under the chapter finds good cause for the release of the identity.

1-07-02 **Confidentiality of Records** T.C.A. 71-6-118

All records of the Department concerning a protective service client must be kept confidential and may not be released except as follows:

- Information may be shared with other agencies or individuals when the sharing of such information is required in order to provide protective services to the client and it is in the best interest of the client to share said information.

- Information is shared according to the Adult Protection Act with law enforcement and/or the Tennessee Department of Health.

- Any other requests for access to information in the APS files should be given to the regional DHS attorney for a determination to be made as to the legality of sharing such information.

- Information is shared with the licensing authority of a facility (TDH or TDMH/DD) concerning the initial report **(excluding the identity of the reporter)** and the investigative findings with a recommendation for further action, if indicated.
  T.C.A71-6-103(d)

1-07-03 **Use of Confidential Information** T.C.A. 71-6-103

Any information obtained from another agency or professional, the confidentiality of which is protected by another statute, may not be used except insofar as it may be necessary to carry out the provisions for the Adult Protection Act or as authorized by the respective statute.

If there is a question about the confidentiality of information or the use of that information, legal advice from the DHS attorney should be requested.

1-07-04 **Violation of Confidentiality** T.C.A. 71-6-118(c)

Any person violating the confidentiality of the reporter or records is guilty of a Class B misdemeanor, and if convicted, may be fined not more than five hundred dollars ($500) and may, in the discretion of the court, be confined in the county jail or workhouse not exceeding six (6) months. T.C.A. 40-35-111

1-08 PENALTY FOR ABUSE, NEGLECT OR EXPLOITATION

T.C.A. 71-6-117; 71-6-119

It is unlawful for any person to willfully abuse, neglect, or exploit an adult as defined by this chapter. Such a crime is a Class A misdemeanor and upon conviction a person may be imprisoned for up to eleven (11) months twenty-nine (29) days or fined up to twenty-five hundred dollars ($2,500) or both. T.C.A. 40-35-111

Willful physical abuse or gross neglect of an impaired adult with resulting serious mental or physical harm shall be punishable as an aggravated assault. T.C.A. 71-6-119

1-09 RECORDING IN PROTECTIVE SERVICES FOR ADULTS CASE FILES

It is essential that the APS case file accurately reflect what has transpired with a client who is receiving services from DHS. A full picture of the investigative, assessment and service activity with the client will enable staff to:

- engage in appropriate case planning,
- document APS response times and contacts;
- document the services provided to the client (which is necessary for fiscal and legal accountability),

- provide an accurate source of information when legal action is taken,

- assure continuous services during counselor absences or vacancies, and

- aid supervisors and program staff in responding to requests for case consultation.

The consideration made in fully evaluating the client's condition and needs should be included in the recording. Any i**nformation** obtained or **observations** made which are used in **case planning** and **decision-making** must be included in the recording.

Any **changes** related to service needs which occur during APS involvement with the client must be reflected in the case recording or case assessment.

The purpose of case recording is to substantiate the counselor's actions and conclusions. It should support the information recorded on the 2861, but need not repeat that information (See Section 4-03-01, Case Assessment Form 2861 and Impact on Case Recording).

Characteristics

Case recording should be **concise, factual, objective, relevant** and **reliable**.

Concise is comprehensive, but free of unnecessary words.

Factual contains accurate information about what occurred, was observed, was said, or was decided.

Objective is factual information and does not include any assumptions or opinions. Because of the nature of APS, case files may be subpoenaed by court as evidence; therefore, speculation, gossip, conclusions, and assumptions based on insufficient facts should be avoided. Opinions and conclusions based on fact are sometimes essential for explaining case decisions; these should be given with the supporting facts.

Relevant pertains to the allegations of the report or other risks which are to be addressed.

Reliable is free from subjective interpretations of the facts, with clearly labeled and attributed quotes. Judgments and opinions should be labeled as such with their supporting evidence.

Medical information should always be attributed to the source; labels or diagnoses should not be used unless furnished by a medical professional.

Opinions or remarks may be included if enclosed in quotation marks and the source indicated.

Facts are straight-forward, known or observed activities, circumstances and decisions. They may also be information drawn from official records or documents.

Observations are recorded notes of other individual's behavior or circumstances as seen by you or reported to you by others. In recording observations, the source of the information must be clear.

Interpretations are conclusions or opinions based on gathered facts and observations. Interpretations require ample evidence to support them. Be careful that interpretations of other persons' statements and behaviors are identified as such and not recorded as facts.

1-09-01 Recording Format - Dictation

Each case file must include a description of each contact made on the case. The descriptions provide a means to organize and analyze case information. All major case decisions must be supported by the dictation entries or assessment information identified on the Form 2861.

Components of Each Entry

Each Entry must include

- the full date (date, month, year)
- full name of person contacted and relationship to the client
- full name of the APS Counselor (or other DHS employee) making the contact
- type of contact, for example: phone, home visit, office visit, etc.
- full names of persons present during the contact
- summary of issues discussed, emphasizing relevant information pertaining to the presence of risk factors
- observations made by the APS Counselor, those observations that are relevant to the allegations and risk factors

- any opinions or judgments made by the APS Counselor as a result of the contact
- statement of future action to be taken or pursued

Dictation entries may be legibly handwritten, typewritten or computer entered.

Contacts are to be recorded in the case file within five working days of the contact.

EXCEPTION: Numerous attempts to contact a person may be summarized in one entry. for example, "1/2/95 - The APS Counselor attempted to contact client by telephone four times today."

1-09-02 **Recording Format - Progress Reports**

Progress reports are completed at least once every **six months** following the initial assessment or previous Progress Report. The six-month Progress Report will reflect the progress and/or changes in the case and whether or not services are needed. If continued services are needed, the need will be explained and the specific services/interventions will be identified.

Progress reports are completed more often if major changes occur in the case. These changes may make the initial Service Plan obsolete and create the need for a new plan. If changes to the existing Service Plan are needed, document the revised plan on Form 2754, Adult Protective Services Service Plan, with the date of the revision.

Progress Report Guide

Case Name:

Progress Report:

Summarize in narrative form any significant changes in the adult's circumstances and/or situation since the preceding assessment. Special emphasis should be placed on the degree of successful reduction in previously identified risks and by which service alternatives/interventions they were achieved. After summarizing changes, risk reduction and services rendered, identify new or continued areas of risk which document an ongoing need for Adult Protective Services, including the current Overall Level of Risk with justification for the assigned risk level. As in the initial assessment, state the revised Service Plan, if any, and state how the plan will be implemented.

If previously identified risks have been fully addressed, and no new risks have been identified, then closure of the APS case should be completed. Document the closure on Form 2750, Case Closure Summary.

This progress report should be concise. It should only highlight key points already detailed in the ongoing recording of case contacts. It should not repeat the kind of detail itemized in the original assessment but, as previously stated, should be used to pinpoint **change/progress** and to **establish a new Service Plan or case closure.**

Date of Progress Report _____
Date of Transcription _____
Worker _____
(Signature) (Date)
Supervisor _____
(Signature) (Date)

1-09-03 Abbreviated Documentation of APS Investigation/Assessment

In a limited number of case situations full documentation may not be necessary. See **4-16 Abbreviated Documentation of APS Investigation/Assessment**.

1-09-04 Contents and Organization of the Case File

The minimum required contents of a case record at closure include:

- 3 ACSS print screens
  - Adult and Community Services Case Information – shows approval date and computer transaction dates including closure
  - Adult and Community Services Individual Information – shows type of report, closure risk and closure reason
  - ACSS APS Client Closure Data – information gathered from the Closed Case Questionnaire.
- form 700 (HS-0055) Adult Protective Services Intake
- form 1215 (HS-0875) report to law enforcement and licensure except in those cases which are alleged to only involve self-neglect
- assessment form appropriate for the Case: 2861 Assessment Form, 2638 Facility Investigation Form, **or** 2630 Abbreviated Documentation of Investigation)
- Service Plan (Form 2754) in cases in which services are needed and planned when the assessment is completed
- recording of case contacts and activity as described above in Section 1-09-01
- legal referral (HS-2752) in any case in which a referral was made to the APS attorney for legal assistance
- signed court order(s) in any case in which there was a court hearing
- medical records, reports of evaluations, financial records and any other information needed to investigate and/or provide services
- progress report(s) in cases open longer than 6 months and closure as described above in **Section 1-09-02**
- Case Closure Summary Form 2750

A standardized organization of the case file is needed:

- for consistency;
- for ease of document retrieval
- to expedite case reviews as needed

The file folder should be organized as follows:

LEFT HAND SIDE OF FOLDER

- 2861 or other appropriate assessment form (2638 or 2630) and narrative dictation
- pages attached along the inside margin, so that pages can be turned like a book;
- assessment form (2861, 2638 or 2630):
  - the earliest assessment form closest to the front cover, the latest, most current assessment form on top;
  - forms filed so that each page can be read up to the margin without having to turn the file or remove pages from the folder.
  - each assessment form followed by the narrative dictation related to contacts for the relevant assessment and any subsequent service contacts.
- narrative dictation:
  - pages of narrative dictation filed chronologically with earliest dates toward the front, so that pages can be read sequentially by turning like a book with all parts of the entry visible.

RIGHT HAND SIDE OF FOLDER

- ACSS print screens.
- all other documents including Intake Form 700.
- the most recent 700 will be on top, under the print screens.
- as much as possible, reduce producing documents with writing on front and back for the right hand side of the folder, which will require turning the folder or removing pages to be read.

EXPANDABLE FOLDERS

These larger case folders with built in tab sections and fasteners are useful for filing those cases which have a large volume of documents such as medical and/or legal records or contacts from various agencies which will be more easily found grouped in separate sections.

- attach those papers which have writing on both sides along the side margin so that both sides can be read. If fasteners are placed at the top, write, print or copy pages on one side only as much as possible.

1-10 USE OF INTERPRETERS/TRANSLATORS WITH CLIENTS WHO ARE DEAF/HARD OF HEARING OR HAVE LANGUAGE BARRIERS

In the course of investigating or providing services to APS clients, it is not unusual to encounter clients who, as a result of the aging process or through illness are deaf or hard of hearing, or have other disabilities that affect communication. Successful communication may also be hindered if the individual is non-verbal or has limited English proficiency (LEP). Many of these clients have not learned alternative ways to communicate and must depend on relatives or other caregivers to provide information for them.

To insure that these clients are being afforded the opportunity to make their needs and circumstances known, APS counselors should make available a certified interpreter rather than a relative or caregiver, especially during an investigation or when assisting the client to obtain medical care. See **Section 1-16** Civil Rights Protections.

All interpreters/translators whose services are used must possess the necessary qualifications and fluency to thoroughly and accurately communicate with Adult Protective Services clients and others who may be needed during the investigation or provision of services. They must be bound by a code of ethics with maintenance of confidentiality being part of their professional conduct, and they must maintain the confidentiality required in the Tennessee Adult Protection Act.

1-10-01 To Arrange For an Interpreter/Translator:

1. SERVICES FOR DEAF AND HARD OF HEARING

It is the responsibility of the Tennessee Registry of Interpreters for the Deaf to compile and update annually a list of qualified interpreters for those who are deaf or hard of hearing, and to make this list available to DHS legal staff. APS staff should refer to and select a service provider from this list. For persons who are unable to speak or write due to illness, medical or mental condition or accident, and who require the use of persons capable of interpreting, DHS will determine, based on experience and education, who should be utilized as a resource.

When an interpreter for the deaf or hard of hearing is needed to complete the APS investigation, and/or assist with service provision, DHS legal staff should be notified and the communication documented in the case file. APS staff should refer to and select a service provider from the listing of qualified interpreters provided to DHS by the Tennessee Registry of Interpreters for the Deaf to DHS legal staff.

After services have been provided, a cover letter referencing the communication about the need for interpreter services and verifying that the services were completed, needs to be submitted to DHS legal staff with an original invoice and the completed Authorization to Vendor form for processing and payment. See Appendix, **Section 11-02-02**, Arranging for Interpreter/Translation Services and Procedures for Payment. Maintain copies of the letter, invoice and payment form in the case file.

When communicating by telephone with someone who is deaf or hard of hearing and who has a **text write telephone**, APS staff can utilize TTY (teletype writer) services. There is no charge for the service in Tennessee other than customary telephone charges. The number is 1-800-848-0299. This number will access a relay operator who will convert the caller's voice message into a text message for the deaf/hard of hearing person, and convert the typed response into a voice message. Telephone relay operators are bound by confidentiality.

2. TRANSLATION SERVICES FOR THOSE WITH LIMITED ENGLISH PROFICIENCY

For communication with persons who have limited proficiency in the English language (LEP), the services of a translator may be needed. APS staff has access to translation services that are provided by a statewide contract for state agencies to ensure compliance with Title VI. (See Section **1-16**) The translation service is accessed by telephone and can be used by APS staff to translate face-to-face as well as telephone conversations. All DHS staff should be provided with current information about the contract provider, current procedures and access codes for translation services. Information about the service is available as well in each county office and from APS supervisors.

1-11 SPECIAL CASE REVIEW TEAMS

Each unit will have access to a team which will conduct special reviews of specific adult protective services cases. The teams will review case situations in which one of the following criteria apply, or those which are identified by the Department's management, outside professionals, political leaders, or cases in which the media have voiced serious concerns about our service delivery.

To avoid the team becoming the primary means for handling routine complaints or overreacting to outside pressures, the use of the team is limited to these specific types of cases. The classes of adult protective services cases to be automatically referred to the APS Program Supervisor for review by the team include:

1. Active cases or cases which were in open status sometime during the 90 days prior to:

   - an adult fatality due to abuse or neglect,

   - an adult fatality when DHS has a court order to consent to services to prevent death, or

   - serious physical injury/illness (requiring in-patient hospitalization) of an adult due to self-neglect, abuse or neglect inflicted after the case was opened.

2. Other complex case situations as determined by the Field Supervisor or Program Supervisor and may include exploitation, abuse, neglect, or death.

3. Cases which are the basis of civil suits against DHS or DHS staff.

4. Cases which receive intensive or extensive media coverage.
   Cases are reviewed by the team to assess:
   - the effectiveness of Adult Protective Services casework intervention;
   - evaluate appropriateness of the application of Adult Protective Services policy and the law;
   - determine the need to make revisions in Adult Protective Services policy, procedures or the law;
   - identify training needs;
   - support DHS staff directly involved when that is appropriate.

The team will be convened on an as needed basis. The teams are composed of the APS Program Supervisor, the case APS Field Supervisor and APS Counselor, a supervisor and counselor not involved in the case, a representative of the local APS Case Consultation Team; and other District and State Office staff in selected cases, such as cases involving the media or cases identified by DHS management.

These steps in the Special Case Review process should be followed:

1. NOTIFICATION:

When an incident occurs that meets the criteria in the review process, the local staff must immediately notify the regional APS Program Supervisor or State Office staff by telephone, E-Mail or FAX. “Immediately” means on the day the staff become aware of the incident.

2. CASE FILE

Within 24 hours of becoming aware of the incident, the APS Counselor or Supervisor must submit copies of all case materials to the APS Program Supervisor or APS Program Director.

3. STAFFING

The APS Program Supervisor will review the file, determine appropriateness for team review, and convene a case staffing. The staffing will be held within 30 days of the incident and should address the nature and effectiveness of the casework intervention, the application of law and policy, and the experience gained from this case that may aid in future practice.

A brief report of the team's findings will be forwarded within 10 working days to the APS Program Director with a copy to the Director for Child Care, Adult and Community Programs. The report should include findings addressing the following:

- casework effectiveness
- policy compliance
- corrective action, if needed
- recommendations for future agency practice or training
- policy or legal recommendations.

Each Program Supervisor will maintain a copy of each report for 3 years.

1-12 INVESTIGATIONS INVOLVING A DHS EMPLOYEE AND HIS/HER FAMILY

Use special care when assigning cases for investigation that involve a DHS employee or employee's relatives as the alleged perpetrator or victim. Normally these cases should be assigned to staff from outside the county in which the employee in question works.

Respond immediately upon receiving the referral by notifying the Program Supervisor of the receipt of the referral.

The Program Supervisor assigns the case for investigation. The investigating counselor must be extremely sensitive to the confidential nature of this type of case.

Inform the Program Supervisor of the finding; the Program Supervisor will then deal with the situation.

After the investigation is complete, maintain the record in the state office.

1-13 SUPERVISORY APPROVAL AND ACCOUNTABILITY

Supervisor approval by signature on service plans, closing summaries or dictation is not required. However, supervisors are responsible for the provision of quality services within the APS unit. Supervisors are responsible for devising methods/systems which ensure the protection of vulnerable adults and that case decisions are made based on accurate assessments, service plans are appropriate and service provision is based on these plans.

Critical case decision points include classification of the case, six month reviews, case transfers and case closures. Supporting components to the assessment and critical decision points include the case recording, supporting documentation and other case record documents, such as signed court orders, correspondence, etc.

1-14 HANDLING PROPERTY/POSSESSIONS OF APS CLIENTS

There are two (2) primary types of situations in which the access to and handling of a client's property/possessions may become an issue. These situations are:

1) Cases in which DHS is involved in legal action to place or remove a client under the protective services program, or
2) Cases in which APS is investigating, assessing or providing protective services to a client but legal action has not been initiated or planned.

1-14-01 Ethics and Protection

The mission of Adult Protective Services staff is to protect vulnerable adults from abuse, neglect or financial exploitation. The population APS protects is by definition vulnerable (impaired, dependent, unable to protect themselves). All employees have a duty to avoid financial, business, personal or other relationships which might compromise the public's interest or cause a conflict with the performance of their duties. Adult Protective Services staff by the nature of the work they do must have the highest ethical standards.

Basic Rules:

1. Never profit or gain from any contact with an APS client or from access to his/her property, possessions, resources, funds, etc.

2. **Avoid even the appearance of a conflict of interest** in contacts with APS clients, or access to their property, possessions, resources, funds, etc.

Keeping in mind the above rules and knowing that there are situations in which a plan will need to be made which will protect a client and comply with the two basic rules, the following guidelines are provided to assist in decisions regarding case planning and activities.

1-14-02 **Guidelines**

These apply to **all** APS clients, not only to adult clients who have substantial amounts of real or personal property, or substantial liquid resources in a financial institution, but also to those with only modest personal possessions. The APS focus is on the safety and welfare of the individual. APS does not want to assume responsibility for belongings or funds of clients. However, there are times when the adult's well-being may to some extent be affected by what happens to their possessions or other resources.

Cases Involving Court Intervention

Take reasonable steps to secure property/belongings. If DHS staff are ever to take possession of any APS client's property/belongings, maintain a clear paper and/or witness trail to track the items and what is done with them. Signed receipts or written statements are critical in maintaining a system of documentation and tracking.

Discuss with a DHS attorney actions to take to protect, secure or dispose of any property belonging to an APS client. Legal options include: asking for a temporary guardian to be appointed under T. C. A. 71-6-107(a)(6) if the adult has sufficient resources to defray the costs of care in a case involving DHS legal intervention seeking to provide protective services; or asking for a conservator to be appointed under the Conservatorship Act, T. C. A. 34-11-101, et. seq. See Legal Intervention, **Section 6-05-06** and **Section 6-17**.

Injunctions may be considered to protect the client's resources/property.

Even when there are items of personal property which are of small value, a court order should be requested in order to direct the disposition of the property/resources.

APS Access When Court Action is Not Planned

APS staff should avoid having possession of the property, possessions, or resources/funds of a client. In those situations in which it is necessary in

order to protect the client or in an emergency situation, use the two basic rules and take all safeguards to avoid the appearance of a conflict of interest.

1. CLIENT MAY BE LEAVING THE HOME

When deciding the best action to take:

1) Ask the client what they want done (specific ideas or preferences). If possible, obtain in writing or with a non-DHS witness present.
2) Secure the home, apartment, papers and valuables to the extent possible.
3) Maintain any keys in a safe location.
4) Encourage the client to take any important papers with him/her and request that they be tagged and locked up (if possible), i.e.: hospital, nursing home, etc.
5) If DHS has a means of storing any items and consideration is given to doing so, then list all items and have a second party sign the list. Two DHS staff should sign as receiving the items and two need to sign when they are returned. Ask DHS attorney to draft a release of liability statement for the client to sign.
6) Identify other service providers, or DHS volunteers who may be able to assist. Having a different agency involved will reduce the potential conflict for DHS.
7) If a client dies while any of his/her property is in our possession, notify the DHS attorney. Disposition will be determined by the court.
8) APS Counselors must ensure and document that their supervisors are aware of any cases in which a counselor has or needs to have access to the resources or property of an APS Client.
9) Notify the police if a person is going to be out of his/her home for an extended time.
10) Ask police to be present and assist in securing property.
11) Ask DHS Area Manager to assist in documenting, witnessing or securing possessions, or arranging for the assistance of a registered volunteer.

2. ASSISTING THE CLIENT IN THE HOME

Staff will make every effort to avoid handling the money or property of clients. If at all possible, a trusted family member, neighbor, friend or appropriate service provider should be identified to assume this responsibility. APS staff are limited to handling the client's money or property in situations in which:

A. The client's immediate welfare and/or safety is involved, such as paying a utility bill, needing groceries or medication, etc.

B. The client is unable to perform the task even with assistance from APS staff.

C. There is no other reliable person available to take this responsibility.

D. Social and/or recreational activities are never reason for APS staff to handle client's money, property, etc.

The following safeguards will be followed when handling the client's money or any possessions, etc., to ensure that there is no conflict of interest, profit or gain from the activity, or the appearance of profit, gain or conflict of interest.

1) Perform only activities that relate to the service plan and/or serve to reduce risk and contribute to the safety of the client.
2) Supervisory approval must be obtained before the activity is performed. If that is not possible in an emergency, the reasons and subsequent approval must be documented. The supervisor must be informed of the activity as soon as possible in those cases.
3) Any money handled (cash or checks) must be for the express purpose of paying a bill or purchasing commodities for the client.
4) Obtain a signed statement for any cash, etc., received from the client stating:
   - the amount given,
   - to whom,
   - for what purpose
   - signed and dated by the client.
5) When the task has been completed, the statement will show what was returned to the client (cash, goods, etc,) and be signed and dated by the client. (See **Sample Client Statement** below.)
6) Checks will be made out to the utility company or business with whom the transaction is to be made—**never** to cash or to APS staff.
7) If a utility bill is being paid, return the stamped receipt to the client.
8) If groceries or medications are being purchased, return the itemized receipt to the client.
9) Obtain a signed statement from the client for the goods and/or any change. The cost of the items purchased and change will exactly correspond to the amount of money which was initially received.
10) APS staff will accept **NO** gratuity, either in cash or in kind, no matter how small. Staff will **NEVER** accept purchase of anything by the client.

VIOLATION OF THE ABOVE WILL BE GROUNDS FOR DISCIPLINARY ACTION.

SAMPLE STATEMENT FOR HANDLING CASH, RESOURCES, ETC.

_____ given to _____

for_____

_____ _____
Client's Signature Date

$_____ and _____

returned to _____

_____ _____
Client's Signature Date

_____ _____
Approved by (Supervisor) Date

Verification must be maintained in the case file

1-14-03 **Criminal Actions**

DHS staff who improperly dispose of the adult client's property or resources can be subject to litigation including charges of theft or fraud. Additionally, the Official Misconduct Act (T. C. A. 39-16-401, et. seq.) states that a government employee who uses his/her position for profit or gain may be prosecuted for a Class E felony. APS staff themselves may be prosecuted under the Adult Protective Services Act for financial exploitation.

1-15 PERSONAL SAFETY AND CLAIMS FOR COMPENSATION

In the performance of their duty, APS staff may from time to time find themselves in situations which pose some hazard to their safety and/or well-being, whether from communicable disease, a contaminated environment, criminal activities in the community, hostile and angry individuals or other hazardous conditions. Staff are never expected to jeopardize their life, health or safety. There are procedures and precautions which can help ensure the safety of APS staff as well as reduce risk to clients.

See **Section 14 HEALTH AND SAFETY** for specific recommendations related to:

1. volatile situations or individuals
2. methamphetamine use and production
3. AIDS
4. hepatitis
5. TB

1-15-01 Workman's Compensation

There may be situations in which, despite reasonable precautions, staff may be exposed to communicable disease, other health hazard or incur injury or damage to or loss of property while in the performance of their job. In such situations the staff member may be eligible for compensation for medical expenses or for property. Following are the steps for filing a claim for compensation. For clarification or additional information, contact DHS Personnel.

1. Inform the APS supervisor of any injury, health concerns, property loss or damage, etc.

2. Before seeking medical care, call Sedgwick Claims Management Service to obtain the name of the closest preferred medical provider in your area. Using a non-preferred provider can jeopardize the claim for the state to cover medical bills. If the need for medical care is so urgent that staff must go to a hospital or emergency room immediately, Sedgwick should be called at the first opportunity before incurring any further medical costs.

   The phone number for Sedgwick is 1-800-526-2305. After regular hours and on weekends, there will be a beeper number to contact a Sedgwick representative. To obtain this number when away from the office, call DHS Personnel.

3. Obtain the following 2 forms and fill them out:

   - Accident Report RDA 1178 (TR-0231). This form is the claim for compensation for medical costs, etc. It can be obtained from DHS personnel, Workman's Compensation **or** on the Internet as follows:
     - Go to the State of Tennessee webpage, www.state.tn.us.
     - In the left-hand column, point to Government and in the pop-up box, click on *For State Employees*.
     - Click on *Employee Benefits and Policies* in the middle of the page.
     - Under "See Also" in the right hand column, click on *Worker's Compensation For State Employees*.
     - On the "Worker's Compensation" page, click on *Forms* in the left hand box.

- On the "Worker's Compensation Forms" page, click on *Accident Report*.

Note: This form also has a portion which must be completed by the supervisor.

- Employee Safety Incident Report. This form is an internal DHS record of any incident involving harm or threat of harm to the employee. It will also serve to notify the department of loss of or damage to property and will be routed to office services to handle the claim. It can be obtained from DHS Personnel.

4. Both completed forms should be sent to:
   Workman's Compensation
   Personnel, Department of Human Services
   3rd floor
   Citizens Plaza Bldg.
   400 Deaderick St.
   Nashville, TN. 37248-9700

   Note: If the reports are faxed, originals will still need to be mailed to the above address.

5. Claims for compensation for property damage or loss are processed through the Board of Claims. For more information, contact the DHS Department of Personnel.

6. Inquiries about the status of a claim for loss of or damage to property can be made to DHS Office Services.

1-15-02 Ordering Protective Supplies

For staff concerned about contamination from communicable disease, hazardous environment, etc., protective coverings can be ordered. Directions for ordering supplies follow in Sections **1-15-03** and **1-15-04**.

Note that none of these items can be obtained immediately upon request, and would need to be available for staff to use promptly. They should be ordered to be available when needed.

1-15-03 General Services Central Stores

Disposable gloves are available from General Services Central Stores. They can be ordered at the regular time for monthly orders by the designated person in the county office. If the item is not already on the list for ordering, the Program Supervisor can tell the person who submits

monthly orders to add it to the list.

1-15-04 **Special Order Supplies**

Following are some items that staff may request as needed to provide protection from communicable disease or biohazards such as meth sites:

- face masks
- disposable protective shoe coverings
- disposable protective clothing coverings
- disposable protective coverings for car seats

These may be requested from Office Services as special orders as follows:

1. Program Supervisors send a memo to DHS Office Services requesting a cost analysis of the item(s), with a copy to the APS Program Director.

2. Office Services does a cost analysis of the item(s) and sends the information to the Assistant Commissioner for approval.

3. If approved Office Services submits requests to suppliers for bids and orders the items from the selected provider.

1-16 TITLE VI—CIVIL RIGHTS PROTECTIONS

POLICY STATEMENT

The Tennessee Department of Human Services, at all administrative levels, will not discriminate against any client, employee or contractor in any program aspect, for reasons of age, race, color, sex, disability, religious creed, national origin, or political belief.

The Adult Protective Services program works with agencies and service providers in every part of the community in an effort to help our clients remain self-sufficient in a safe environment for as long as possible. In addition to the limited direct services utilized to protect the APS client, APS staff responsibilities over the years have expanded in the areas of linking clients to existing local services and advocating for the APS client when services are cut/denied or when there are conflicts/complaints about the services/providers. In this role APS staff are responsible for knowing about the civil rights laws that ensure equal and fair treatment for our clients by our program as well as those other programs that provide services to these vulnerable adults.

1-16-01 Federal Nondiscrimination Laws that Apply to Adult Protective Services

Federal laws that prohibit discrimination in federally funded agencies apply to the Adult Protective Services program and the actions of DHS contractors and service providers, just as they do other federally funded programs and their providers. An overview of the federal laws that prohibit discrimination in any federally funded program is listed below:

- **Title VI of the Civil Rights Act of 1964** – prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives federal funds or other federal financial assistance.

- **Title VII of the Civil Rights Act of 1964** – prohibits private, state, and local government employers with 15 or more employees, and employment agencies from discriminating on the basis of race, color, sex (including pregnancy), religion or national origin in all aspects of an employment relationship. This includes hiring, discharge, compensation, assignments, and other terms, conditions, and privileges of employment.

- **Section 504 of the Rehabilitation Act of 1973** – prohibits discrimination on the basis of disability by employers and organizations that receive federal financial assistance.

- **The Americans with Disabilities Act of 1990 (ADA)** – prohibits discrimination on the basis of disability by both public and private entities, whether or not they receive federal financial assistance.

- **The Age Discrimination Act of 1975 (ADEA)** – prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance.

- **The Equal Pay Act (EPA)** – requires payment of equal wages to men and women performing substantially the same work unless the pay discrepancy is based on a seniority or merit system (a system that measures quantity or quality of production, or a factor other than sex). The EPA applies to employers of any size.

- **Hill Burton Community Service Assurance Act** – requires that hospitals or other health care facilities assisted under the Act provide services to persons residing in the community without discrimination based on race, color, national origin, or method of payment. Hill Burton hospitals may not refuse emergency services because of a person's inability to pay.

- **Drug Abuse Office and Treatment Act of 1972** – hospitals may not refuse to admit or treat anyone needing emergency care solely because that person is dependent on or addicted to drugs.

- **Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970** – hospitals may not discriminate in admissions or treatment against alcoholics solely because of alcohol abuse.

1-16-02 Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency (LEP)

In order to ensure compliance with Title VI, DHS must take steps to ensure that LEP persons who are served by the Adult Protective Services program have "meaningful access" to the program. The most important step in meeting this obligation is to provide the language assistance necessary to ensure "access", at no cost to the person with LEP. The key to providing "meaningful access" for persons with LEP is to ensure that the APS program and the person with LEP can communicate effectively. We must ensure that the person with LEP:

- is given adequate information;
- is able to understand the services available;
- is able to receive those services for which he/she is eligible; and
- is able to communicate the relevant circumstances of his/her situation to the program.

In order to ensure that individuals are not excluded from equal program participation due to limited English proficiency (LEP), the Department of Human Services must provide trained and competent interpreters and other oral language assistance services. The Department may:

- hire bilingual staff;
- hire staff interpreters;
- use volunteer staff interpreters;
- use volunteer community interpreters;
- contract with an outside interpreter service; or
- use a telephone interpreter service—APS has access to interpreter services provided by a statewide contract to state agencies.

See **Section 1-10 Use of Interpreters/Translators With Clients Who Are Deaf/Hard of Hearing or Have Language Barriers**.

APS will use an interpreter resource if necessary to communicate with the referent, the victim, the alleged perpetrator, collateral sources, etc. In a crisis, APS is still be able to use whoever might be available to interpret and facilitate efforts to get critical information to address the crisis situation.

1-16-03 Filing Discrimination Complaints:

Any individual or his/her representative alleging racial/ethnic/national origin discrimination by personnel of the Department or a Family Homes for Adults sponsor should be instructed to file a complaint with the local Title VI Coordinator (DHS Area Manager). This complaint may be written using Form HS-2631*, Complaint Under Civil Rights Act of 1964* (available from the Area Manager and on the Intranet), by writing a letter or be made verbally to the Area Manager. A complaint may also be filed at the state or federal levels (see contact information below), separately or concurrently, at any time during the process.

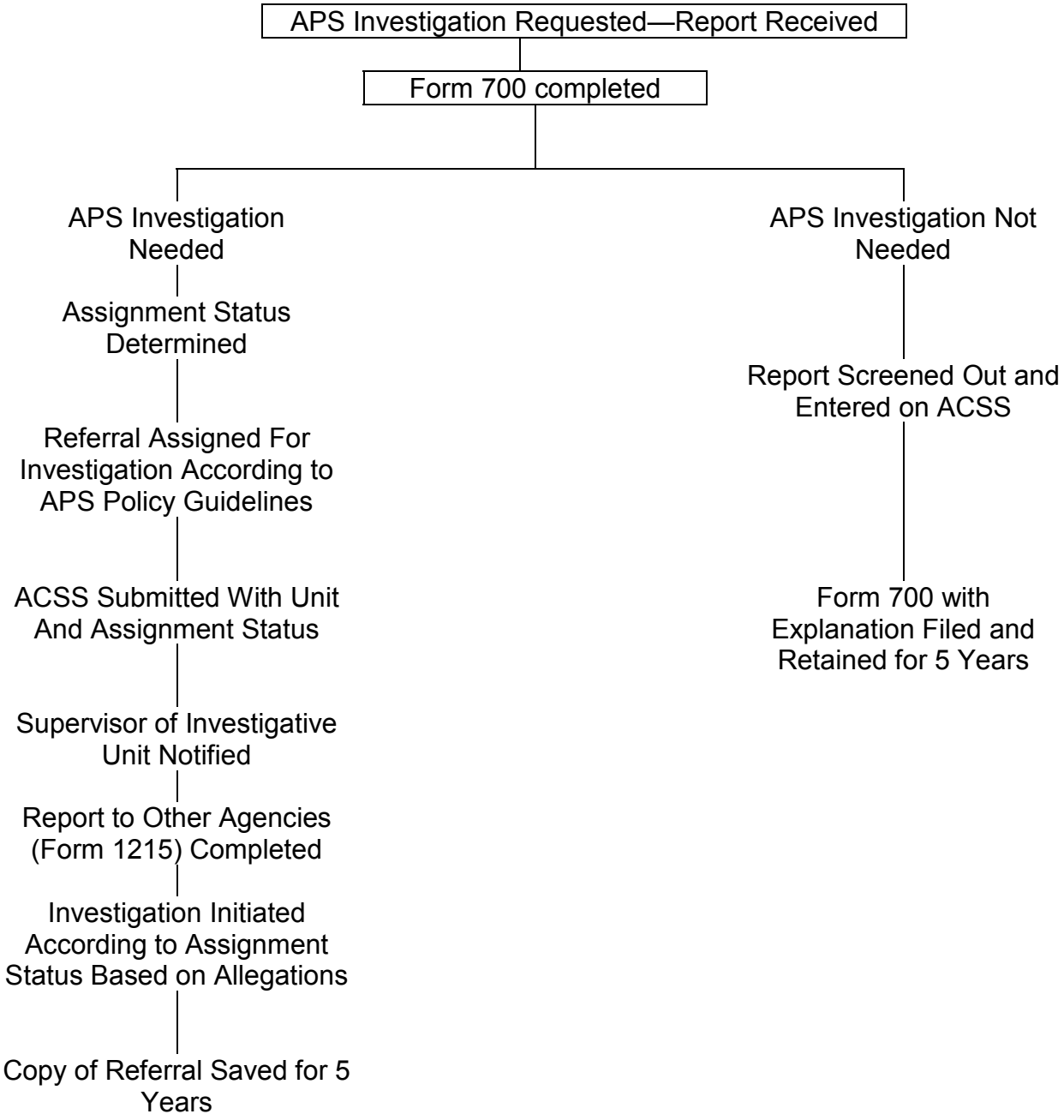
- State level –
  Tennessee Human Rights Commission
  530 Church Street; Suite 400
  Nashville, TN 37243-0745
  Phone: (615) 741-5825

- Federal level –
  U.S. Department of Health & Human Services
  Office of Civil Rights
  Atlanta Federal Center
  61 Forsyth Street, S.W., Suite 3B70
  Atlanta, GA 30303
  Phone: (800) 368-1019 / (404) 562-7886

  When a complaint is received the Area Manager will send the original to the DHS State Office, Title VI Coordinator, and a copy to the APS Program Director. The Area Manager will initiate an investigation into the allegations and follow-up on the investigation will be completed by the DHS State Office, Title VI Coordinator.

SECTION 2 - INTAKE

FLOWCHART



SECTION 2 - INTAKE

2-01 INTAKE INTERVIEW

The purpose of the intake interview is to obtain sufficient information to establish the adult's eligibility/need for the protective services investigation and to determine the assignment status based on risk to the client.

The intake process is critical to the provision of protective services. Sufficient information must be obtained during the intake interview(s) to show the adult's need and appropriateness for initiation of the protective services investigation. Enough information should be obtained to enable the counselor to evaluate the concerns of the person making the referral. **The information obtained will indicate how emergent the needs of the adult may be which will effect how the referral is assigned**.

Effective and thorough intake can assure that adults in need of protective services receive needed services as soon as possible based on the allegations. Since the intake interview is the beginning of the casework/service delivery process, it has important casework consequences. Intake may also have important legal implications. Although a small percentage of the cases referred require legal intervention, the information gathered at intake may be useful evidence if court action is necessary.

To ensure accurate and thorough communication and to comply with Title VI Civil Rights Protections, the intake counselor must be alert to recognize any barriers that may arise due to impairments and/or limited English proficiency (LEP). To assist with communication, APS has access to foreign language interpreter services, TTY telephone services for the deaf/hard of hearing and/or other community services that provide interpreter/translation services. See **Section 1-10-01 To Arrange For An Interpreter/Translator**. See **Section 1-16** for information about federal Civil Rights Protections.

2-02 REFERRALS/REPORTS TO APS

The Department accepts and investigates referrals which allege that an adult who because of mental or physical dysfunctioning or advanced age is unable to protect himself/herself and is being abused, neglected, or financially exploited or is at imminent risk of abuse, neglect or financial exploitation. (Adult Protection Act, T.C.A.71-06-101 et seq.) See definitions in T.C.A. 71-6-102

No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be

subjected to discrimination under any program or activity receiving federal financial assistance. (Title VI of the Civil Rights Act of 1964, as codified in 42 U.S.C.2000d.)

Referrals come to the Department by telephone, in writing or by people making referrals in person. In the event that a written referral is not legible or the contents cannot be clearly discerned due to handwriting, effects of fax or any reason, intake will contact the referral source to obtain clarification of the allegations. In those situations in which such an unclear written/faxed report is received from Health Care Facilities Intake Unit, APS intake will contact Tennessee Department of Health-Health Care Facilities Centralized Intake Unit for clarification of the report. (1-877-287-0010, M-F 7:00 a.m. to 7:00 p.m.)

Self Referrals

Requests for services may come in many forms and the words "neglect, abuse, or exploitation" may not always be used by the person asking for services. The key is for counselors to be keenly aware of the meaning of what the client is saying and be able to interpret the needs they have described. The fact that a person requests services for himself/herself does not mean that he/she is able to protect himself/herself. Such a request by an adult client is actually a self-referral for protective services when the described condition falls within the definition of an adult being unable to protect himself/herself and being harmed or threatened with harm.

An adult may request help because he/she:

- is being subjected to abuse, neglect and/or exploitation by a caretaker or other person and the adult may believe that he/she is unable to prevent the abuse. The adult may fear that he/she will not be able to survive if the caretaker puts him/her out of the home or leaves.
- is unable to consistently obtain necessities for daily living and/or perform essential tasks needed for health and safety, and requests our assistance. Careful questioning may reveal a significant level of risk which warrants protective services.

Institutions, Etc.

Referrals from institutions and other facilities may involve special considerations or procedures. See "Investigations Involving Institutions, Boarding Homes, Residential Homes, Nursing Homes, etc." in **Section 7**. Referrals of incidents involving patients/residents in facilities operated by the Tennessee Department of Mental Health and Developmental Disabilities, and **occurring in those facilities** will not be investigated by APS in accordance with T.C.A. 71-6-103(k). Reports of harm to patients of those facilities

occurring while the adult is outside the facility **will** be accepted for investigation. See **Section 7** and **Section 2-04-04.** See **Section 4-14-03** for the list of facilities operated by TDMH/DD.

2-03 INITIAL DETERMINATION OF NEED FOR PROTECTIVE SERVICES Form 700 (HS-0055)—INTAKE FORM

A **Form 700 (HS-0055)**, Intake Form, must be included in each protective service case file. The Form 700 provides the information necessary to justify initiation of protective services to adults.

Completion of the Form 700 provides the information necessary:

1. to determine the appropriateness of initiating an investigation/assessment;
2. to determine how quickly an investigation should be initiated;
3. to determine where and how to begin the investigation;
4. to know safeguards which may be needed (due to contagious diseases or the presence of weapons, etc.); and
5. to know how to expedite services or help which may be needed by a client who may be found in a crisis.

The **Form 700 (HS-0055)** is completed in full during the intake interview. The intake worker is expected to obtain all information which is relevant to the case and known by the caller. See Sample form in **Section 9.**

Page 1 includes:

- Intake data
- Screen-out-data
- Assignment Information
- assignment status
- referral type(s)
- client demographics (identifying information)
- contact information

Page 2 includes:

— information about the referral source
— information about the clients income.
— information about the client's mental/physical condition(s), limitations, etc., which make the client vulnerable.
— details regarding the harm or risk of harm to the client.
— Information about the alleged perpetrator.
— additional information that will clarify the client's situation and assist the counselor with planning the investigation.

2-04 CONDITIONS OF NEED

In Adult Protective Services, there are essentially two conditions which must be met before an adult can be accepted for a protective services investigation. The adult must be **unable to protect his/her own interests**, and he/she must be at risk in that he/she is **threatened with or is being abused, neglected or exploited**. If the adult is unable to protect himself/herself but he/she is not at risk, then the adult does not need protective services. (Example: The adult with severe retardation who is being adequately cared for by family members.) If the adult is at risk but able to protect himself/herself, then the adult does not need protective services. (Example: The normally functioning adult who is beaten by a neighbor.)

1. Before a protective services investigation and assessment can be initiated there must be **allegations** which at least address these two areas.

2. Before on-going services are provided the assessment must show that **both** conditions are met according to the following criteria.

2-04-01 Adults Who are Unable to Protect Their Own Interests

The adult's inability to protect his/her own interests must be based on his/her mental dysfunction, physical dysfunction or frailty due to advanced age.

a. Mental Dysfunctioning - Mental functioning which is impaired or deficient making the adult unable to recognize the consequences of his/her behavior, unable to identify his/her needs and take the steps necessary to see that those needs are met, or unable to perceive relevant facts and reach a decision based on those facts.

   The adult may be lacking in experiences or abilities to comprehend the risks of his/her actions; or be lacking in abilities to make choices or follow through with appropriate actions that ensure protection, without receiving guidance, support and direction.

   This category may include those who are emotionally disturbed, developmentally delayed or have retardation, as well as those whose abilities to protect themselves are impaired by extreme stress, isolation, confinement or illness, etc.

   This category does not include those adults who function normally and are simply in need of information regarding other services; and, to our knowledge, are able to follow through with obtaining needed services.

   A person may be considered incapable in one phase of his/her life while able to function adequately in other areas. Denial of an obvious problem should lead one to question a person's functioning in that area.

b. Physical Dysfunctioning - The adult is physically unable to protect him/herself from neglect, hazardous or abusive situations and/or to take care of basic needs such as personal hygiene (bathing), necessary shopping (food), bill paying (utilities), food preparation, or obtaining required medical care.

c. Advanced Age - Adults who are 60 years of age or older and are unable to manage their own resources, carry out the activities of daily living or protect themselves from neglect, hazardous or abusive situations.

These adults may be mentally or physically dysfunctional; suffering from personal losses which make adapting to cultural and societal complexities difficult; have grown frail, feeble and/or are isolated, or are victims of other conditions which may be associated with advanced age making them in need of protective services.

2-04-02 Adults Who Are Abused, Neglected or Exploited

Adults who need protective services must also be abused, neglected or exploited or at risk of being abused, neglected or exploited.

Adults who fall within the following criteria will be considered to be abused, neglected or exploited:

a. **Abuse** - The commission of an act to cause physical pain, physical injury, mental anguish, emotional trauma or unreasonable confinement of an adult who is unable to protect himself/herself. Injuries may include conditions which are debilitating or if not treated would become debilitating; or conditions which would cause permanent disabilities; or conditions which would be considered terminal if not treated.

b. **Sexual Abuse** - Sexual abuse occurs when an impaired adult is forced, tricked, threatened or otherwise coerced into sexual activity, involuntary exposure to sexually explicit material or language, or sexual contact against his/her will. Sexual abuse also occurs when an adult is unable to give consent to such sexual activities or contact and is engaged in such activities or contact with another person.

This unwanted sexual contact may include physical and emotional abuse and verbal harassment of a sexual nature. Sexual abuse may occur regardless of whether or not the perpetrator is the spouse of the victim.

c. **Neglect** - The omission of services/care needed by an adult to prevent physical or mental injury/illness. This is neglect by a caretaker. "Caretaker" means an individual or institution who has the responsibility

for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult person voluntarily, or by contract, or agreement. **Note:** Intent is not a factor.

d. **Self-Neglect** - Neglect includes self-neglect when an adult is unable to obtain for himself/herself services needed to prevent physical or mental injury/illness.

"Self-neglect is the result of an adult's inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs." (Definition adopted by the National Association of Adult Protective Services Administrators, October, 1990.)

Neglect and self-neglect may include failure to obtain/receive needed:

- medical care for serious illnesses;
- other care to prevent physical or mental injury/illness;
- food, or
- provide/maintain safe shelter.

e. Components of Neglect and Self-Neglect are defined below:

- **Physical or Mental Injury/Illness** - Injuries/illnesses which result in conditions which are debilitating or if not treated would become debilitating, or conditions which would cause permanent disabilities; or conditions which would be considered terminal if not treated.

  Conditions which are not accepted as normal for most functioning adults (common cold or mild depression vs. kidney disease or suicidal tendencies.)

- **Medical Neglect** may include situations in which caretakers have failed to seek needed medical care for an adult or situations in which the adult has failed to obtain such care for himself/herself. The needed medical care is believed to be of such a nature as to result in physical or mental injury/illness if such care is not provided.

  Medical care may include the services of physicians, nurses, in-home medical services, hospitalization, required medication, nursing home care, etc.

- **Inadequate food** is failure to receive food necessary to prevent physical injury or to maintain life including failure to receive appropriate food for persons with conditions requiring special diets (diabetics).

- **Inadequate shelter** may be shelter which is not structurally safe; has rodent or other infestations which may result in serious health problems; or may not have a safe and accessible water supply, heat source or sewage disposal. Safe shelter for a person will depend on the limitations of an individual person; however, the person must be protected from the elements which would seriously endanger his/her health (rain/ cold) and result in serious illness or debilitating conditions.

  Clients do not have to have running water or central heat and air in their homes in order to be safe. Wood heat may be perfectly all right for one person but create a danger for another. A client who must rely on wood heat but is physically unable to chop or lift wood will have to have special arrangements made in order to ensure that he/she has heat when it is needed.

- **Inadequate clothing** is the lack of clothing considered necessary to protect a person's health. It is generally expected that an adult needs clothing to provide protection from excessive cold. Inadequate clothing would be clothing that is insufficient or inappropriate for the weather.

f. **Exploitation** T.C.A. 71-6-102(8) - Tennessee law specifically defines exploitation as the **misuse of funds paid** to a person by a **governmental agency**.

   Therefore, referrals based only on exploitation are limited to the definition in the law. If the referral alleges the misuse of funds other than those paid by a governmental agency, then the allegations must also include one of the conditions listed under "a. abuse" or "b. c. or d. neglect" in order for the protective service referral to be accepted. Protective Services would then be provided to alleviate the abuse or the neglect.

   Referrals based **only** on the misuse of funds other than those paid by a governmental agency will not be accepted.

2-04-03 Adults Who Are at Risk of Being Abused, Neglected or Exploited

Adults who are in such a situation that the conditions described in **Section 2-04** are imminent, believed to be impending or believed to be likely

to occur if there is no intervention by DHS are considered to be "at risk of being abused, neglected, or exploited." Counselors must be able to explain their reasons for believing that the client is at risk.

Several examples of the client who may be in a situation which warrants careful evaluation of whether or not harm is impending include the client:

- who has shown his/her inability to follow through with doctor's appointments, medication and counseling sessions and/or other plans or activities to reduce or alleviate conditions that may pose serious risk to health and/or safety without supervision;
- whose health is deteriorating;
- who appears unable to comprehend results of his/her decisions;
- whose history includes allegations of previous sexual or physical victimization;
- whose history includes allegations of A/N/E by a person who is or who will be acting as a caregiver;
- whose living conditions will not be safe when the seasons change (winter);
- who lives in the home of another person where there is resentment of the burden of caring for the client;
- who repeatedly has been without food or utilities;
- who is living in extreme filth including clothes, linen, dishes, etc.; or
- who appears to have adequate income but is having trouble meeting his/her basic needs for food, clothing, shelter, and utilities.

2-04-04 Allegations of Patient to Patient/Resident to Resident Abuse

It will be necessary for the intake counselor to question the reporter as to knowledge of prior incidents, as well as to check for previous APS reports and cases.

1. Reports of Incidents Which are Not Accepted for Investigation

Reports of incidents between patients or residents may be screened-out under the following conditions:

(a) the facility in which the reported incident is alleged to have occurred is a facility **operated** by the Tennessee Department of Mental Health/Developmental Disabilities. All incidents in these facilities are investigated by DMH/DD. See **Section 2-10** Screen Outs. See **Section 4-14-03** for the list of DMH/DD operated facilities.

(b) the incident reported is the first such incident involving either of the patients/residents, **unless severe abuse is alleged**;

(c) the referent has no reason to believe that the incident could have been anticipated by the facility, **and**

(d) the referent believes that the facility, as the caretaker, has responded appropriately to prevent additional incidents.

2. Reports of Incidents Between Residents/Patients will be accepted when:

(a) the referent doesn't know whether or not the facility responded appropriately to prevent further incidents and protect the patient/resident;

(b) the referent is alleging that the facility has not responded appropriately;

(c) the referent is alleging that there have been multiple incidents involving one or both of the patients/residents;

(d) the APS system indicates that there is an open case or that there have been other reports involving this victim;

(e) the referent alleges that the facility could have anticipated an incident (i.e., patient has a history of abusive acting out); or

(f) the allegations include severe abuse.

3. Severe Abuse Definition

Severe Abuse is defined as: any abuse which requires immediate medical attention to treat conditions that could result in irreversible physical harm or any sexual abuse.

4. Report to Licensing, Form 1215

Whether accepted or not, all such incidents will be reported to the appropriate licensing agency via the form 1215. If APS is not investigating, write this information on the 1215 form.

2-04-05 **Reports of the Death of an Adult** T.C.A. 71-6-103(b)(1)

Reports are required to be made to TDHS when abuse, neglect or exploitation is suspected. When the report includes allegations regarding the death of an adult APS will:

1. advise the reporter to contact law enforcement and licensure; See **Sections 2-11. 2-12** and **2-13.**

2. report to licensure, law enforcement (the TBI, as appropriate). Use the form 1215 and indicate that APS is not responding;

3. not accept reports for investigation of a deceased adult; and

4. not open a case in the name of a deceased adult.

If another adult is alleged to be in similar circumstances, then the report as it relates to the client who is at risk will be accepted. The investigation may include obtaining relevant information related to the conditions or actions which resulted in the death of an adult, if this information will help in determining the safety and protection need of the remaining adult client(s). The accepted report will include specific allegations of risk to the adult. The safety of everyone in the facility, on the ward or in the room may not automatically be questioned based solely on the death of a resident/patient. However, if there are allegations of risk toward others, each one will be accepted for investigation and investigated individually.

2-05 INFORMATION TO BE OBTAINED T.C.A. 71-6-103(c)

The law lists specific information which the person making the report to us is required to provide if the information is known to them. Basic information which the person making the referral is expected to provide, if known:

- Name and address of the adult;

- Age of the adult;

- Name and address of the caretaker, if any;

- Nature and extent of the abuse, neglect or exploitation (including any evidence of previous abuse, neglect or exploitation);

- Identity of the perpetrator, if known;

- Any other information that may be helpful in establishing the cause of the abuse, neglect or exploitation.

In addition policy requires that the intake counselor obtain information necessary to establish the assignment status. See **Section 2-08** for explanation of Investigative Priority Register and guidelines for establishing assignment status of referrals.

2-06 GUIDELINES FOR OBTAINING NEEDED INFORMATION AT INTAKE

During the initial contact with the referent it is important to obtain as much information as possible.

The obtained information is needed to determine:

- whether or not the referral is appropriate for investigation;
- the appropriate assignment status;
- Additionally, the information obtained during the intake interview can greatly enhance our ability to do a thorough investigation while expediting the provision of services.

Information to obtain about the adult and his/her situation may include the following:

1. Overall description of the adult.

2. What specifically is the report? Location and description of injuries and/or description of illness(es).

3. When did the incident occur and/or how long has the maltreatment been occurring?

4. What has happened to cause the reporter to make the referral at this time?

5. Does the adult have any acute or chronic illness(es)?

6. Does the adult require physical aids such as a walker, cane, wheelchair or glasses?

7. Description of activities the adult is able to do himself/herself.

8. Description of activities that the adult cannot do for himself/herself.

9. Background on the adult's ability to care for himself/herself, including noticeable changes in health and/or behavior; or any behaviors which

create dangerous circumstances for the client such as hoarding or wandering, how long they have been present, how extensive they are, etc.

10. Who is presently assisting the adult (individuals and/or agencies)?

11. What has been done to assist the adult?

12. Is there a primary caretaker? If so, who?

13. Is the adult in danger at this moment?

14. Information about the alleged perpetrator, including possible reasons for alleged abuse and/or neglect.

15. Did the reporter see the incident?

16. How often does the reporter see the adult?

17. Identity of witnesses to incident or others who have knowledge of the situation (names, addresses and phone numbers).

18. Name(s) of adult's doctor(s), pharmacy.

19. Known medication and/or treatment.

20. Household composition (names and relationships - include related and unrelated).

21. Relatives, friends and/or significant others (names, addresses, phone numbers and relationships)

22. Does the adult have pets?

23. If the adult has a conservator, what is his/her name, address and phone number?

24. Income amounts and sources for adult and/or household members.

25. Overall description of the adult's home.

26. Where is home located in terms of distance from resources and significant others (relatives, neighbors, friends, hospital, etc.).

27. Directions to the home.

28. If the counselor is unable to locate the adult's home, who can help?

29. Identity of the reporter including relationship to the adult.

30. What is reporter's expectation of the services to be provided?

31. Are there unusual or dangerous circumstances for which the counselor should be alert such as methamphetamine production or use, vicious dogs, weapons, etc.?

The above stated suggestions of information to obtain at intake are not to be used as a rigid interviewing guide. Flexibility is essential at intake, since each case situation is different. Because of these differences, every item included in the intake guide will not apply to every intake situation.

2-07 INFORMATION TO BE GIVEN

The intake worker may share all or part of the following information with the person making the referral, as considered appropriate:

(1) The law requires that reports of abuse, neglect and/or exploitation be made. T.C.A 71-6-103

(2) The law protects the reporter from civil or criminal liability. T.C.A. 71-6-105

(3) The Department will contact the person making the referral when the report is assigned to a counselor for investigation if the reporter gives a name and phone number.

(4) If the reporter calls back on an **unassigned report**, asking to whom the case has been assigned, the intake counselor will refer the caller to the investigative supervisor to whose unit the referral was assigned.

(5) The Department will contact the person making the referral, after the client's situation has been evaluated, to advise him/her as to whether or not protective services will be provided. T.C.A 71-6-103

(6) The law protects the confidentiality of the identity of the person making the referral unless we are required by court order to identify the referent. T.C.A. 71-6-118

The intake worker terminates the interview by stating whether or not the referral is appropriate for initiation of an APS investigation/ assessment. If the report is not appropriate, the intake person should share this information with the caller and explain why an investigation will not be initiated. If the intake person needs supervisory consultation, then consultation should be obtained. Once the decision is made regarding the appropriateness of the

report, the reporter should be advised of the Department's decision.

2-08 ASSIGNMENT STATUS GUIDELINES – INVESTIGATIVE PRIORITY REGISTER

All referrals that meet the criteria for APS investigation will be accepted and investigated. They will be assigned for investigation according to the alleged level of risk to the client, a process of triage that allocates staff resources first to those at greatest risk at times when resources may be limited. It is the responsibility of the intake counselor to classify each referral for assignment according to the following guidelines.

Exceptions to the following are those referrals that allege abuse, neglect or exploitation of an adult who resides in a facility operated by DMH/DD **while the adult is away from the facility**. These referrals require immediate assignment due to a Memorandum of Understanding between DHS/APS and DMH/DD. The Memorandum specifies that :

- "Emergency Referrals— . . . the investigation by TDHS/APS will be initiated on the day the referral is received and accepted by TDHS/APS.
- "Non-Emergency Referrals— . . . . the investigation by TDHS/APS will be initiated with five (5) working days after being accepted by TDHS/APS.

See **Section 11-14** for the Memorandum of Understanding between DHS and DMH/DD.

Priority Status--Immediate Assignment
Priority A--Immediate Assignment and Response

(1) Person in imminent danger-critical illness, visible injuries or life-threatening conditions
(2) Abuse--physical/sexual/unreasonable confinement, etc.--which is occurring at the time of the referral
(3) Sexual or physical abuse with the alleged perpetrator having access to the victim
(4) Sexual or physical abuse within the past 72 hours
(5) Reason to believe the caregiver may flee the investigation, move the client or move to an unknown location
(6) Threat of suicide or threat of homicide to the client
(7) Caregiver is requesting APS for fear he/she may harm the client
(8) Reason to believe the client or caregiver is exhibiting psychotic or bizarre behavior which places the client in immediate danger
(9) Neglect or self-neglect in which the client is without essentials for daily living

(10) Client needs total care and has been left without caregiver (caregiver hospitalized, deceased, abandoned client, etc.) and the client's impaired judgment or physical condition puts the client in immediate danger
(11) Sudden deterioration in the client's condition and client may be in imminent danger
(12) Any other factors, that would indicate immediate danger to the client

Priority B--Immediate Assignment - Response 1 to 7 Working Days, Depending on Emergent Nature of Allegations

(1) Serious illness or non-visible injury that has been treated in the hospital and the client was subsequently released to a protective environment
(2) Neglect or self-neglect which puts clients in danger, but short term/ temporary care/protection is being provided
(3) Stressed caregiver reportedly has threatened harm or has requested assistance
(4) Eviction imminent - official notice given
(5) An environmental hazard or condition which places the client in danger
(6) Any factor that will result in serious harm to the client if services are not initiated within seven (7) days such as repeated incidents, an established pattern of harm, medical treatment/services needed to reduce harm
(7) Alleged perpetrator does not currently have access but may gain access to the client within a short time frame
(8) Sexual abuse where the incident occurred beyond 72 hours and the alleged perpetrator currently does not have access and there are no visible injuries.
(9) Reason to believe the client or caregiver is exhibiting psychotic or bizarre behavior that places the client in danger

Status C--Assigned After Priority Reports-Immediate Assignment Not Required -- Assigned Based on Availability of Investigative Staff

(1) Needs some assistance with essential ADLs due to mental/physical condition and assistance is inconsistent but client is not in immediate danger
(2) Client's mental/physical condition/impaired judgment put client at some risk
(3) Eviction is threatened
(4) Lack of adequate supervision or basic needs, i.e. medical care, assistance with ADLs, etc., which, if uncorrected, will endanger client's health and safety
(5) Client inconsistently meets minimal needs for food, shelter, essential ADLs

(6) Caregiver has a reported illness that is untreated or deteriorating to the point that supplementary services must be provided to ensure adequate care
(7) Environmental conditions potentially unsafe, fear of fire or other hazards, no previous history but possibility of putting client at risk
(8) Incidents limited to verbal abuse with some adverse psychological effects such as fear or depression; or concern that verbal behavior may later escalate to physical abuse
(9) Client has suffered physical abuse with no current injuries, and alleged perpetrator is not currently believed to be present or have access

Status D--Assigned After Status C-Immediate Assignment Not Required--Assigned Based on Availability of Investigative Staff

(1) Client needs in-home services (homemaker, Home Health, etc.) to safely maintain independent living
(2) Caregiver has illness or physical disability which requires some services or assistance to enable him/her to continue to provide care
(3) Stressed caregiver is verbally abusive with minimal adverse effects on the client; no concern for potential of physical abuse
(4) Environmental conditions put client at some risk, pest/rodent infestation, unsanitary, plumbing operating poorly
(5) Client has minimal mental/physical disabling condition and allegations meet minimal criteria for APS eligibility
(6) Financial Exploitation only which does not currently cause a lack of essential needs/care

All referrals that meet the criteria for Priority A or B will always be assigned immediately by either the intake counselor or the investigative supervisor. The procedure to be followed will be determined by agreement between the Intake and Investigative unit supervisors.
Referrals that meet the criteria for Status C or Status D assignment will be assigned by the intake staff to the appropriate investigative counselor unless requested by the Supervisor to only do **unit** assignments.

When a unit only assignment is done, then the investigative supervisor will assign the referral to a counselor. The investigative supervisor will update the computer system (ACSS) with the assignment information once a counselor is assigned.

If additional information is received that changes the allegations so that they meet the criteria for a different Assignment Status, the Intake supervisor will change the Assignment Status of the report and assure that the Investigative supervisor is notified.

2-09 DUTY TO REPORT

2-09-01 **Who** T.C.A. 71-6-103(b)

Tennessee law provides that "any person having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made" giving such information to the Department. The law states that death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.

2-09-02 **Liability** T.C.A. 71-6-105

Any person making such a report **shall be presumed to be acting in good faith and shall be immune from civil or criminal liability** for such action.

2-09-03 **Violation of Duty to Report** T.C.A. 71-6-110

Any person who knowingly fails to make a report as required by the Adult Protection Act is guilty of a Class A misdemeanor and upon conviction may be fined not more than twenty-five hundred dollars ($2,500.00) or imprisoned for not more than eleven (11) months and 29 days or both.

2-09-04 **How Reports Are Received – Intake Sites**

APS has four intake sites located in the four urban offices: Knoxville, Chattanooga, Nashville and Memphis. If a report is received at a site which does not cover the county of the client, the report will be taken and sent to the appropriate site. Reports may be received through phone calls, in writing, electronically or face to face contacts.

2-10 SCREEN OUTS - REQUESTS FOR PROTECTIVE SERVICES WHICH ARE DETERMINED TO BE INAPPROPRIATE FOR ASSIGNMENT

Any referral which does not express or imply concern that the adult is in a harmful situation or is at risk of being harmed and is not able to protect himself/herself may be determined to be inappropriate for assignment. Referrals which do not warrant the initiation of a protective service investigation/ assessment may need referrals to other available services and may be referred and handled accordingly. **Note: Any reports of incidents alleged to have occurred in a facility operated by DMH/DD are investigated by DMH/DD without any participation by APS. These referrals are screened out and referred to DMH/DD. Reports of incidents involving harm to adults who are residents in any of these facilities, but which occur while the resident is away from the facility <u>will</u> be accepted for investigation by APS.**

A caller who reports conditions in a licensed or unlicensed health care facility which are not appropriate for APS investigation and/or alleges violations of facility standards which are matters for the licensing agency but do not meet the criteria for APS investigation will be referred by APS intake to the TDH-HCF Centralized Intake Unit toll free number, 1-877-287-0010, M-F 7:00 a.m.-7:00 p.m.

Occasionally a limited number of contacts (primarily telephone calls) may be necessary in order to obtain additional information which may be needed to clarify the need for initiation of an investigation. These contacts may be documented on the Form 700 (HS-0055). In those situations in which the additional information does not justify the initiation of an investigation, the report should then be maintained with other screen outs. Intake FS1s will review all new screen outs at least weekly. See **Sec. 2-15** below.

Whenever a referral has been "screened out" as being inappropriate for a protective services investigation/assessment, the Form 700 (HS-0055) is completed. The reason(s) for considering the referral to be inappropriate for assignment should be documented on the Form 700 (HS-0055) and the information is added to the ACSS.

Each Intake site will maintain these screened out referrals on a Form 700 in a separate folder on the DHS network server reserved for referrals. These files should be kept for five (5) years.

For decision making about questionable referrals, see **Section 2-15** below.

2-11 NOTIFYING LAW ENFORCEMENT T.C.A. 71-6-103(d)(1)

When a referral **alleging abuse, neglect or exploitation of an adult by another person or persons** is received, APS is required to make a report to law enforcement. Referrals of adult neglect, abuse or exploitation will be shared with the local sheriff's department or the local police department. **The report should be made to law enforcement at the time that the referral is received**. We do not wait until the investigation is begun or a determination is made regarding the validity of the referral. Each supervisor will have his/her own system within the following guidelines for reporting either to the sheriff or the police.

1. If the person making the referral indicates that physical or sexual abuse or life endangering neglect is occurring or death has occurred at the time of the referral, the designated law enforcement agency shall be called immediately; otherwise, the basic information may be mailed on Form 1215 (HS-0875) to the designated law enforcement agency within two (2) working days of receipt of the referral. On those referrals which are reported to law enforcement by telephone, the Form 1215 will also

be completed and mailed to law enforcement. A copy of the 1215 is maintained in the case file.

2. Any report of the death of an adult due to abuse or neglect will be reported to law enforcement **immediately**, at the time the referral is received. T.C.A. 71-6-103. Report as described above.

3. Reports will be made to law enforcement when the referral includes an allegation which involves an adult client being harmed by another person. The harm may be in either of two forms: a) Commission of acts against the adult, i.e., physical abuse or b) Omission of services needed by an adult who is left in the care of another person, i.e., caretaker denies the adult needed food.

   If the allegation involves **self-neglect** and no other allegations are made, then law enforcement will not be notified (i.e., an adult who lives alone and who refuses to go to the doctor).

4. The written report, Form 1215 (HS-0875), to law enforcement includes the following information:

   a. Name, address and age of the adult.
   b. Allegation made regarding the adult.
   c. The alleged perpetrator's name, address and relationship to the adult.

   The name of the person making the referral will **not** be given in the report. The complainant's name may be included as a witness if witness information is needed. However, we **cannot** identify the complainant as the reporter of harm, without being ordered by the court to do so. **If the referral is FAXED to law enforcement, the reporter's name must be removed.**

2-12 NOTIFICATION TO THE TENNESSEE BUREAU OF INVESTIGATION (TBI)

Referrals which allege abuse, neglect or exploitation and meet specific criteria should be reported to the Tennessee Bureau of Investigation (TBI), **as well as** to local law enforcement.

A report to TBI should be made when a referral meets **each of** the following criteria.

1. Abuse, neglect or exploitation occurred in a medicaid-funded facility (example: nursing homes, institutions),

or

The alleged incident(s) occurred in a Board and Care Facility **regardless** of whether payment is made from **medicaid**; but the resident/patient is a TennCare recipient. Board and Care Facility includes residential settings such as assisted living residences, residential homes, etc.

Exception: Patient-to patient abuse will be reported **only** when there is an allegation or implication by the referral source that the abuse was related to neglect by the facility staff.

and

2. There is physical evidence (body fluids, visible trauma, weapons, etc.), an eye witness, or a pending medical report which may document physical evidence.

3. If the alleged abuse or neglect placed the adult in a potentially life-threatening situation, or involves serious bodily injury, death or any type of sexual assault.

4. An allegation of verbal abuse which caused the adult to reasonably fear imminent bodily injury.

Any referral which meets the above criteria should be reported by telephone or FAX to the TBI agent identified for your area (See **Appendix 11-11**). Referrals which do not strictly adhere to the above criteria may be reported as well if the counselor feels the referral warrants TBI evaluation for possible investigation.

It is possible that a counselor's investigation may reveal that there is evidence as stated in criteria #2 which was not alleged in the referral. This new information should be reported to TBI by telephone or FAX within 24 hours.

The Form 1215 (HS-0875), Report of Alleged Abuse, Neglect or Exploitation of an Adult, shall be used to FAX the report to the TBI. It shall also be used when the report was telephoned to the TBI to follow- up on the telephone referral. TBI should be checked in the line which begins -- **"Report sent to: ...."**

Include the following information if known to APS:

- Victim's name, address, phone number, date of birth and social security number;
- Perpetrator's name, address, phone number, date of birth and social security number;

- Allegations, including:
  a. location of incident (bathroom, bedroom, hallway, closet, etc.);
  b. witnesses' names and contact information for them;
  c. description of physical evidence;
  d. brief synopsis of allegation.

Note: As with other reports to law enforcement, the name of the referent is not given verbally or in writing. When the referral is made by the Tennessee Department of Health-Health Care Facilities, **the fact that the report came from HCF may be shared with TBI,** although the **name of the person** who made the report is **not** shared.

2-13 NOTIFICATION TO THE LICENSING AUTHORITY

T.C.A. 71-6-103(d)(2)

Notify the appropriate licensing authority if the report concerns an adult who is a resident of, or at the time of any alleged harm, is receiving services from, a facility that is required by law to be licensed, or the person alleged to have caused or permitted the harm is licensed under title 63.

These reports are made upon receipt of the referral as specified in 1 & 2 below.

Reports are made to the following if the report involves residents or patients of licensed facilities, clients receiving services from licensed facilities, or if the alleged person causing or permitting harm is licensed by the health licensing laws:

- Persons licensed under title 63 are reported to the Tennessee Department of Health (TDH) – Health Related Boards. See **APPENDIX 11-05** for the list of professions licensed under title 63 and where the 1215 should be sent.

- Nursing Homes are reported to the Tennessee Department of Health (TDH) - Regional Offices Health Care Facilities (**Appendix 11-04**).

- Homes for the Aged and Residential Homes for the Aged are reported to the Tennessee Department of Health (TDH) - Regional Offices - Health Care Facilities (**Appendix 11-04**).

- Hospitals, Residential Hospice and Assisted-Care Living Facilities are reported to the Tennessee Department of Health (TDH) – Regional Offices – Health Care Facilities (**Appendix 11-04)**

- Home Care Organizations (Home Health, Hospice, Home Medical Equipment) are reported to the Tennessee Department of Health (TDH) – Regional Offices – Health Care Facilities (**Appendix 11-04**)

- Residential facilities for mental health and mental retardation services are reported to the Tennessee Department of Mental Health and Developmental Disabilities (TDMH/DD) – Regional Offices (**Appendix 11-06**)

- ICF-MR facilities are reported to the Tennessee Department of Mental Health and Developmental Disabilities (TDMH/DD) – Regional Offices (**Appendix 11-06**. [Note: They are certified by TDH but licensed by TDMH/DD.]

1. If the person making the referral indicates that physical or sexual abuse or life endangering neglect is occurring at the time of the referral, the appropriate licensing authority will be called immediately. The Form1215 (HS-0875) will also need to be completed and mailed on those referrals which are reported to TDH by telephone.

2. Any non-emergency referrals should be shared within two (2) working days of receipt of the referral by DHS.

3. Information to be shared with the licensing authority includes the following:

   - name, address and age of the adult;
   - name of the licensed facility should be included under the address;
   - allegation(s) made regarding the adult; and
   - the alleged perpetrator's name, address and relationship.

4. **The name of the person making the referral must not be given in the report.**

5. All reports require a notification using the Form 1215.

6. Some reports may require multiple notifications including the licensing board for the person and the facility.

2-14 COMPUTER DOCUMENTATION

If the report is accepted for investigation, the intake data entered must be entered the day of acceptance or the following morning. This will put the case on the Adult and Community Services System (ACSS), which is the source of Adult Protective Services program data including caseload assignment, etc.

If the report is rejected for investigation, the screen out data must be entered on the ACSS the day the screen out decision is made.

2-15 DECISION MAKING FOR SCREEN OUTS

Screen outs are allowed only for the following reasons:

1. No abuse/neglect/exploitation
2. No physical or mental impairment
3. No abuse/neglect/exploitation or impairment
4. No abuse/neglect/exploitation but referred for other services
5. No physical or mental impairment but referred for other services
6. No abuse/neglect/exploitation or impairment but referred for other services
7. Abuse/neglect/exploitation occurred in a facility operated by MH/DD

The procedure for decision making related to a referral being accepted or screened out is as follows:

A. Referrals assigned inappropriately

1. Intake counselors gather information and accept referrals for assignment based on APS law and policy.

2. Once a referral has been determined to be appropriate for assignment by the intake counselor or intake FS1 and has been assigned to a counselor for investigation, **it cannot then be screened out**.

3. If there is a question about the appropriateness of a referral, the Investigating counselor will discuss it with his/her FS1.

4. The Investigating FS1 will contact the Intake FS1 to discuss the criteria of alleged impairment and threat of harm in the referral in question.

5. If both FS1s concur that the referral was assigned in error, e.g. the criteria were not met, the Intake FS 1 will discuss this with the intake counselor as a training activity.

6. If the FS1s do not concur on the assignment of the referral, then the Program Supervisor will be sent a copy of the referral in question.

B. Inappropriate screen outs—referral should have been assigned

1. Intake FS1s review all screen outs at least weekly.

2. The Intake FS1 returns any inappropriate screen outs to the intake counselor

   a. for the counselor to accept and register the referral for investigation.

   b. to discuss it as a training activity;

2-16 OFFICE PROTOCOLS AND COVERAGE

Policy requires that the intake phones, at all intake sites, are covered at all times during office hours for the office where the site is located and for the hours of the counties covered by the individual site. This **excludes** special extended hours which may be provided by other programs within the department.

1. It is the responsibility of each Intake Supervisor to ensure that there is a plan for coverage of the intake phone lines at all times during the office hours for the APS program.

2. In the Intake Supervisor's absence or if the Intake Supervisor cannot be contacted, it is the responsibility of Intake staff at each site to ensure that:
   a. the plan for coverage is followed;
   b. should illness or other event cause scheduled staff to be absent leaving intake phones uncovered, that staff will ensure that other assigned intake staff is able to cover the intake phone (this includes the use of staff at other Intake sites to provide coverage), or
   c. that the Program Supervisor is notified in a timely manner in order to make alternative arrangements for coverage of the intake phones.

3. When training or other events are scheduled for Intake staff, either:
   a. staff will stagger attendance at the event so that there is phone coverage, or
   b. arrangement will be made for staff from another site to provide coverage.

4. **All** intake staff will be responsible for noticing any potential breakdown in the established plan for coverage and take the initiative to work together and/or contact supervisory staff as needed to ensure that alternate plans are made for coverage.

SECTION 3 - INVESTIGATION

Checklist

Referral was responded to within time frames

Referent was notified when referral was assigned

Adult client was interviewed alone and face-to-face

All allegations were identified and investigated

Information needed for assessment was obtained

Existing Medical information obtained (most cases)

Medical and/or psychological evaluation obtained

Persons or agencies with information needed to verify allegations or other concerns which may warrant APS were contacted

If court intervention is being considered, the Form 1125, Physician Statement, may be completed

Need for emergency intervention was determined

When necessary, emergency services were provided

SECTION 3 - INVESTIGATION

3-01 THE DEPARTMENT WILL INVESTIGATE COMPLAINTS OF ABUSE, NEGLECT OR EXPLOITATION OF ADULTS

T.C.A. 71-6-103(d)(3)

Upon receipt of a report of suspected abuse, neglect or exploitation the Department is required to initiate an investigation of the complaint.
T.C.A. 71-6-103(d)(3)

The purpose of the investigation is:

1) to determine the validity of the allegations made concerning the adult client,
2) to determine the extent of harm or danger to the adult,
3) to gather the information needed to assess whether or not protective services are needed, and
4) to identify areas of service needs and provide protection for the client when necessary.

To achieve the goal of reducing or eliminating the risks to the adult a thorough investigation is necessary. It is possible for us to be unable to document the need for Protective Services based on the allegations, but during the investigation, other Protective Service needs may be identified which must be addressed. It may also be determined that the client does not need Protective Services, but he/she may wish to be referred for other available social services.

3-02 ENTER PRIVATE PREMISES TO INVESTIGATE

T.C.A. 71-6-103(f)

Any representative of the Department may with the consent of the adult or caretaker enter any private premises where any adult alleged to be abused, neglected or exploited is found in order to investigate the need for protective services.

If the adult or caretaker does not consent to the investigation, a search warrant may be issued upon a showing of probable cause that an adult is being abused, neglected or exploited. The search warrant will enable a representative of the Department to proceed with the investigation. (See **Section 6-10** - Search Warrant.)

3-03 ACCESS TO RECORDS AND INFORMATION T.C.A. 71-6-103

Any representative of the Department actively involved in an Adult Protective Services investigation shall be allowed access to:

- **the mental and physical health records of the adult which are in the possession of any individual, hospital, or other facility; T.C.A. 71-6-103(j)(1)**
- **any law enforcement records or personnel records not otherwise specifically protected by statute, of any caretaker of the adult or the alleged perpetrator; T.C.A. 71-6-103(j)(2)**
- **financial records of the adult, any caretaker or any alleged perpetrator that are contained in any financial institution; (T.C.A. 71-6-103(j)(4)**

when necessary to complete the investigation. However, if the Department obtains any confidential information from another agency, then the Department of Human Services may not disclose such information except as may be necessary in carrying out the provision of the Adult Protection Act or as may be authorized by the respective statute. (See **Section 1-07** on Confidentiality.)

The Privacy Rules pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) provides the first comprehensive federal legislation aimed at protecting the confidentiality of clients' medical records and health information. Under the HIPPA Privacy Protections, there are certain "Permitted Reasons to Disclose Information" without obtaining the individual's permission (45 C.F.R. § 164.512(c). These permitted disclosures include:

- "about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect or domestic violence"
- "to a government authority . . . authorized by law to receive such reports . . "

Therefore, if a health care provider cites HIPPA Privacy Rules as a reason for not providing health care information, the provider is in error. Under both state and federal law, APS can be provided with health care records without permission from the patient.

An exception to the Department's authority to have access to mental health records is records of drug and alcohol treatment. The department must have a signed release from the patient, or obtain a court order, before these records can be shared.

3-04 INITIATION OF INVESTIGATION

Priority A--Immediate Assignment and Response

(1) Person in imminent danger-critical illness, visible injuries or life-threatening conditions

(2) Abuse--physical/sexual/unreasonable confinement, etc.--which is occurring at the time of the referral

(3) Sexual or physical abuse with the alleged perpetrator having access to the victim

(4) Sexual or physical abuse within the past 72 hours

(5) Reason to believe the caregiver may flee the investigation, move the client or move to an unknown location

(6) Threat of suicide or threat of homicide to the client

(7) Caregiver is requesting APS for fear he/she may harm the client

(8) Reason to believe the client or caregiver is exhibiting psychotic or bizarre behavior which places the client in immediate danger

(9) Neglect or self-neglect in which the client is without essentials for daily living

(10) Client needs total care and has been left without caregiver (caregiver hospitalized, deceased, abandoned client, etc.) and the client's impaired judgment or physical condition puts the client in immediate danger

(11) Sudden deterioration in the client's condition and client may be in imminent danger

(12) Any other factors, that would indicate immediate danger to the client

The investigation shall be initiated on the day the referral is received.

With less emergent referrals, investigations will be initiated within one (1) to seven (7) working days **from the date the referral is assigned to the counselor for investigation**. Decisions regarding response time will be based on the emergent nature of each referral and will take into consideration the safety and well being of the client. Any delays before initiating an investigation must be explained in the case record.

Exception: Those referrals alleging abuse, neglect or exploitation of adults residing in a facility operated by DMH/DD, the maltreatment being alleged to have occurred outside of the facility, are assigned and responded to according to the Memorandum of Understanding between DHS/APS and DMH/DD:

- These referrals are assigned immediately upon being accepted.
- Allegations of an emergency nature are responded to the same day the referral is accepted and assigned.
- Allegations which are non-emergency are responded to within five (5) working days from the date the referral is received.

See **Section 2-08** for assignment guidelines. See **Section 11-14** for the Memorandum of Understanding.

The investigation begins when the first contact is made to obtain information needed to determine the validity of the allegations which were made in the referral. This does not include 3-05 a or b (below).

Face-to-face contact with the client is recommended as the routine first contact; however, it is not required as the **first** if other contacts are needed and are more appropriate for a specific report.

3-04-01 Special Provision in Emergency Situations—Use of Law Enforcement

This provision is limited to special situations involving multiple priority reports requiring immediate response on different cases. The following must exist:

- The only way to ensure that a client in alleged dangerous circumstances is seen immediately is to ask local law enforcement to do a "welfare check";
- Multiple reports requiring immediate response are received on the same day;
- Neither the assigned Counselor nor her/his supervisor is able to respond to all the emergency reports on a timely basis; and
- Counselors in contiguous counties are unable to respond to the emergency reports.

Under these conditions the APS supervisor may approve a request from the assigned APS Counselor to ask law enforcement in the client's county to check on the client's condition and safety. Although it is acceptable to do this

in extreme situations, it is important to follow-up with law enforcement as quickly as possible. Contact by law enforcement does not substitute for the APS investigation. Give careful consideration when deciding which of the multiple reports law enforcement will be asked to "check on." Delaying the involvement of APS could impede the APS investigation and assessment; as the client may be threatened, moved or less likely to share information once the immediate crisis has passed.

3-05 GUIDELINES FOR COMPLETING AN INVESTIGATION

In completing an investigation the following steps may be taken:

a. Search available records to determine any previous involvement by DHS with the client.

b. Discuss the referral with the person who made the referral. **It is required that the referent, when available, be notified that the referral has been assigned for investigation if the referral was not immediately assigned to a counselor when accepted for investigation.**

c. The adult client **must** be interviewed. This is required in the law.

   The investigation shall include but is not limited to, a personal interview with the individual reported to be abused, neglected or exploited.
   T.C.A. 71-6-102(10)

d. Consult with others having knowledge of the facts.

e. Request information from appropriate agencies and/or persons which have knowledge of the situation i.e. medical reports, etc.

f. Needed mental or physical examinations may be ordered by the court in some circumstances. (See **Section 6** - Legal Intervention)

g. "When abuse or neglect is allegedly the cause of death, a coroner's or doctor's report shall be examined as a part of the investigation." T.C.A. 71-6-102(10)

The aforementioned steps are not in sequential order and the counselor should use his/her discretion regarding what is to be done and the order in

which it is to be done. However, **adult clients must be interviewed** or the case record must clearly reflect the attempts made to interview him/her and why it was not possible.

3-06 APS INVESTIGATION

To investigate means to inquire into something systematically and to examine it in detail.

The investigation of a report of A/N/E is probably the most difficult part of casework. It becomes an integral part of the helping process when it is conducted with an apparent desire to help.

3-06-01 Planning

A key element of the investigation/assessment approach is planning and preparation. You will benefit from knowing as much as possible about the victim and the situation before the initial face-to-face encounter.

When an APS referral is received the counselor should thoroughly review the report, identifying **each allegation** reported. Every allegation should be specifically addressed during the investigation and the findings documented in the case file.

A thorough, complete search for **prior reports** and service history should be conducted to provide information regarding any past or present contact with DHS, as well as any past or on-going services that have been provided. If a prior case is located, the case file should be reviewed for possible **patterns** of self-neglect or abuse/neglect by a second party or caregiver. Look for cycles of family violence or histories of alcohol or drug abuse. Note the source of previous reports and the names, addresses and phone numbers of resources previously available to the victim.

Any information that can be obtained about the client's **financial status** is important. Many clients receive some form of public assistance and these records should be checked if possible. Be alert to any indication that large sums of money or property may be at stake. Since A/N/E may be motivated by these factors, the client's financial status should be determined as soon as possible in the investigative process.

The reporter must be notified when the investigation is initiated if the referral was not immediately assigned at intake. The reporter should be asked about:

- any changes in the client's situation which may have occurred since making the report;

- other collaterals who may need to be contacted prior to the initial face-to-face visit;
- other pertinent information which the reporter may have that may impact planning the investigation;
- unusual circumstances or hazards the counselor should be alert for.

3-06-02 Initial Contact

Depending upon the nature of the referral, you may or may not choose to telephone for an appointment or advise of your arrival. If the report alleges abuse or neglect by a caregiver or other person who is in the home, you will not want to alert the alleged perpetrator or give them an opportunity to threaten or coerce the client in any way.

The initial contact with the client should be in person. A face-to-face interview is required and the client should be interviewed when the alleged perpetrator is not present. The primary caregiver should also be interviewed, preferably not in the presence of the client.

If the primary caregiver is suspected or alleged to be the perpetrator, caution should be exercised when making the decisions of when and where to interview the caregiver. Consider the possible elevated risk to the client. If a disclosure of abuse or serious neglect has been obtained, be sure that a plan has been developed and steps taken to insure the safety of the client. This must be done before confronting the perpetrator, especially if the offender is living with or has easy access to the client.

3-06-03 Conducting the Investigation

An APS investigation is a fact-finding process in which data is collected, analyzed and weighed in order to make decisions which assure an adequate assessment and protection of the vulnerable adult.

In conjunction with the risk assessment factors, a comprehensive investigation must be conducted in order to make an accurate and well documented decision on each allegation in the referral and the overall need for protective services.

Every step taken and all information collected during an investigation has the potential to be examined in court. While most adult cases of A/N/E do not result in court action, evidence must be gathered and collected as though every case will be contested in court. Evidence collected must be credible and in order for it to be credible, it must be:

Relevant - it must have bearing on the case

and

Reliable - it must be collected and evaluated honestly and truthfully.

The continuous assessment of risk is of prime importance to the investigation. Protection of the client is of foremost concern. Therefore, the counselor must be able to determine the relative level of risk to the client. As each new piece of information is gathered about the client's physical and mental condition, the home, the caregiver's action or inaction, or the perpetrator's identity, the assessment of risk is enhanced.

3-06-04 Locating the Client

Some cases may present difficulties in locating the client due to inaccurate or insufficient information in the referral, the client moving to another county or the client having been temporarily removed from the home. The counselor must make every effort to locate the client within the required time frames to ensure the safety of that individual. Contact should be made with neighbors, relatives, landlords, postal workers, utility companies, etc. in a diligent effort to locate the person alleged in the referral to be in danger. Only after all possible sources of information have been pursued should a case be closed as "unable to locate". All efforts to locate the client must be clearly documented in the case file.

3-06-05 Interviewing the Client

When the client has been located, consideration should be given to the immediate circumstances. If the client is not at home alone, your attention probably will be focused on convincing the caregiver or family member to let you in the home.

Be prepared to encounter distrust, hostility, anger and a variety of defensive reactions. Stress your role as a helper and approach your interview from that angle. Point out that you are there to obtain information, understand the situation and to determine whether or not there are services which are needed.

After entry has been gained, begin by interviewing the client alone and in a quiet and **private** place, away from the presence of the caregiver or relative. Recognize that the client may not feel comfortable if the alleged perpetrator is in the house within hearing distance. Rather than receiving erroneous information or putting the client at further risk, you may choose to keep your questions very general or communicate with the client by writing or using the

special "abuse" cards. It may be necessary to make another visit at a time when the caregiver/perpetrator is not present.

Keep in mind that it is not unusual for more than one type of abuse or neglect to be occurring and **screen every case for multi-faceted abuse**.

Allow the client to respond to **each allegation**, one at a time. The client may state outright that one or all allegations are true. However, it is not unusual for clients to initially deny the allegations. The client's statement of denial must be verified by further investigation. Collateral sources must be used to substantiate abuse, neglect or exploitation. Therefore, the victim's denial of the allegations, **with no other verification, is not sufficient for judging a report invalid**.

Encourage the client to give a complete account of the allegations, bearing in mind that in many instances, the client will have positive feelings about the perpetrator and may try to assume responsibility for the maltreatment.

During the interview, it is necessary to determine:

- **Need for immediate medical assistance.**
- **The nature of the allegations and the extent of any injuries.**
- **The client's relationship to, and attitude toward, the alleged perpetrator and other members of the household.**
- **The nature of the client's disability and/or age impairment.**
- **If previous incidents of abuse, neglect, or exploitation have occurred. This information will help you to assess the dynamics of household members and the level of risk to the client should he/she remain in the present environment.**
- **What the client wishes to do about the situation and offer alternatives, as appropriate.**
- **Other persons with an interest in or information about the client's well-being.**

In some cases, the client may be physically or mentally incapacitated to such an extent that he/she is unable to communicate reliable information. A decision regarding the victim’s inability to reliably communicate must not be made unless ample interview time is spent with the client and a variety of techniques are used in an effort to communicate. Do not assume that reliable information cannot be obtained from the client solely because he/she appears to be confused or disoriented.

If there is a need for interpreter and/or translation services to ensure that the person and APS staff can communicate effectively, see **Section 1-10** for procedure to access services. See **Section 1-16** regarding Title VI Civil Rights Protection that ensure equal access to benefits regardless of race, age or national origin.

3-06-06 Collateral Contacts

Collateral contacts should be made promptly. Medical information is critical to the assessment process and should routinely be obtained, both from the client and the client's physician. Rarely should a situation be taken at face value without any contacts beyond the client.

3-06-07 Observations

In conjunction with the verbal interview of the client, the investigation must include environmental observation and observation of the client's injuries and condition. Observations are as important to the investigation as interviews. Observations should be made as discreetly as possible. To assess harm or risk to a vulnerable adult, accurate observations of facts must be made: the nature, severity, frequency of abuse, neglect or exploitation; the location of injuries; and physical conditions of the home. In addition to physical indicators of abuse and neglect, all behavioral and nonverbal messages that the client might display should be observed and documented.

3-07 NEGLECT INVESTIGATIONS - Special Considerations

If there to investigate allegations of neglect (caregiver or self), be cognizant of these issues:

- physical status and level of functioning
- health problems or impairments
- types and dosages of medication
- dates and names of physicians on prescription bottles
- signs of intoxication
- mental status
- environment
- support systems
- personal appearance
- monetary resources
- household composition

3-08 PHYSICAL ABUSE INVESTIGATIONS - Special Considerations

If the referral alleges physical abuse:

Be aware of family dynamics. How do family members relate to the client and to each other?

Notice non-verbal signals, attitudes, body language and avoidance of questions.

Find out about individuals who come in and out of the home, how often and why.

Explanation of how an injury occurred is not consistent with the type or degree of injury.

Physical Evidence

Observe physical evidence. Injuries may be present in areas normally covered by clothing. Note:

Unusual locations or types of injuries; document size, location and appearance
Injury on head, scalp or face
Bruises or hematomas:
Bilaterally on soft parts of the body, not over bony prominences (knees, elbows).
Inner arm/thigh bruises are very suspicious
Clustered, as from repeated striking
Shaped similar to an object or hand/thumb/finger marks
Presence of old and new bruises at the same time as from repeated injuries or injuries in various stages of healing.

Dating of bruises:

0- 2 days	swollen, tender
2- 5 days	red - blue
5- 7 days	green
7-10 days	yellow
10-14 days	brown
2-4 weeks	clear

Bruises following a recent change of health care providers or after prolonged absence from a health care agency.
Fractures, falls or evidence of physical restraint (abrasions or bruising around wrists and/or ankles).

Contractures (permanent shortening of muscle or tendon) may indicate confinement for long periods.

Unusual fear of a caregiver.

3-09 SEXUAL ABUSE INVESTIGATIONS - Special Considerations

Direct sexual expression or sexual activity must be recognized as a normal aspect of human behavior. An adult has the right to make responsible choices regarding the acceptable expression of his/her sexual needs or desires. A problem in the area of sexuality is the attitude of some that people

who are elderly or who have a disability cannot, are not, or should not be involved in sex.

Also, problematic is the often held belief that the elderly or disabled are not vulnerable to sexual abuse or assault. This belief is supported, in part, by the erroneous idea that sexual assault/abuse is about the fulfillment of "uncontrollable" sexual passion.

Although not yet widely studied, **sexual abuse of the elderly and disabled does occur**, and is a known fact. Also known is that sexual abuse of vulnerable adults is about the **misuse of power and authority**, not sexual attraction. Potential victims are identified based on vulnerability and accessibility. The most frail, the most dependent, the most impaired, the least powerful, and the least able to communicate are the most likely to be victims and are given least credibility. Most often the perpetrator is a family member and/or a caregiver. Spousal sexual abuse is especially challenging and will most likely require consultation with the staff attorney to determine the type of legal intervention which may be possible.

Not all adult sexual contact with elders or impaired adults is abusive. Sexual contact may be appropriate if it is consensual and occurring between two adults who are legally capable of granting consent. It may be necessary, as a part of the investigation, to establish that the client is legally capable of granting informed consent and has given his/her consent.

3-09-01 Conditions Under Which Sexual Contact is Abusive:

Incestuous relationships may be illegal and considered immoral and improper, but between adults, incestuous contact may be consensual. In adult relationships the question to be answered is whether or not both parties are

fully able to give their informed consent. If there is no evidence of coercion or manipulation and both parties are able to give their informed consent and are free to leave the relationship at any time, the incestuous contact is illegal but not abusive as there is no "victim."

Following are descriptions of conditions under which sexual contact would be considered to be abusive:

- Impaired adult is physically forced into sexual activity
- Impaired adult is pressured or manipulated into sexual activity
- Impaired adult is unable to grant informed consent
- Service provider has sex with impaired adult client (abuse of trust, authority and power)

3-09-02 **Sexual Abuse Continuum—Developed by H. Ramsey-Klawsnik**

The Sexual Abuse Continuum, developed by Dr. Holly Ramsey-Klawsnik, delineates the range and types of sexually abusive behaviors. The activities listed are ranked in order from least to most severe in terms of the degree of violence and trauma to the victim. Sexual abuse often begins with the activities in the less severe range and escalates over time to more severe forms of abuse.

COVERT SEXUAL ABUSE	SEXUALIZED RELATIONSHIP
	SEXUAL INTEREST IN VICTIM'S BODY SEXUALIZED JOKES, COMMENTS, HARASSMENT "ROMANTIC" RELATIONSHIP DISCUSSION of SEXUAL ACTIVITY
	PRE-TOUCHING PHASE
OVERT SEXUAL ABUSE	VOYEURISM EXHIBITIONISM INFLICTING PORNOGRAPHY ON VICTIM
	SEXUALIZED KISSING AND FONDLING
	VICTIM IS PASSIVE RECIPIENT
	VICTIM ACTIVITY IS FORCED
	ORAL-GENITAL CONTACT

DIGITAL PENETRATION OF VAGINA OR ANUS

VAGINAL RAPE WITH PENIS

ANAL RAPE WITH PENIS

VAGINAL/ANAL RAPE WITH OBJECTS

EXPLOITATION

SADISTIC ACTIVITY

RITUALISTIC ABUSE

3-09-03 Signs and Symptoms of Possible Elder Sexual Abuse

The following is a list of signs and symptoms of possible elder sexual abuse developed by Dr. Holly Ramsey-Klawsnik. These signs/ symptoms should also alert the counselor to possible sexual abuse of adults of any age who are disabled.

The presence of one or more of the following indicators does not mean that sexual abuse is occurring, but should suggest the possibility, prompting the counselor to carefully screen for sexual victimization.

- Genital or urinary irritation, injury, infection, or scarring
- Presence of a sexually transmitted disease
- Intense fear reaction to an individual or people in general
- Nightmares, night terrors, sleep disturbances
- Phobic behavior
- Mistrust of others
- Extreme upset when changed, bathed or examined
- Regressive behaviors
- Aggressive behaviors
- Disturbed peer interactions
- Depression or blunted affect
- Poor self-esteem
- Self destructive activity or suicidal ideation
- A coded disclosure of sexual abuse

3-09-04 Sexual Abuse Response Time

Any referral which alleges injuries requires a same day response.

Referrals that allege that an incident of sexual abuse has recently occurred (within 72 hours) should be responded to on the same day and effort should be made to obtain a medical exam as there may be physical evidence of sexual assault remaining.

Law enforcement should be notified immediately by telephone when the referral alleges sexual abuse or when sexual abuse is identified during the investigation of other allegations.

Consideration should be given to the client's circumstances in deciding the appropriate response time. Information regarding the client's situation, obtained prior to interviewing the client may be beneficial. Contacting collaterals prior to contacting the client may be appropriate and useful. The safety and well-being of the client should be of foremost concern in the decision regarding the response time, but any delay in response time should be explained in the case recording.

3-09-05 Interviewing the Victim

The purpose of the investigation is to validate or invalidate the allegations stated in the referral and to identify other areas of risk and service needs. Because sexual abuse is often difficult to talk about and is often not considered in association with impaired adults, the referral may not specifically identify sexual maltreatment as the problem. The counselor, however, should be aware of sexual abuse as a possibility. Experts agree that it is highly unusual for only one type of abuse or neglect to be occurring and **every case should be screened for multi-faceted abuse**.

If the alleged perpetrator is the primary caregiver or someone who has regular access to the client, interviewing the client may have to be postponed until a time when the perpetrator is away from the home. A disclosure is unlikely if the client knows the perpetrator is in the next room or is present when the interview takes place.

Whether the client is elderly or is disabled in some way, sexual abuse is emotionally and sometimes physically traumatizing and the client needs a calm, non-judgmental, reassuring, supportive response from the counselor. Because sexual abuse is about the loss of control, it is especially important for

the client to be given as many opportunities as possible to control the disclosure of his/her own abuse. For example:

1) Let the client choose where the interview will take place.
2) Always ask where the client would like for you to be seated.
3) Address the client by using his/her last name unless permission is given to do otherwise.
4) Use language that is clear and on the client's own level, asking open-ended questions and moving at the client's pace.
5) Ask only one question at a time.
6) Resist the urge to touch the client, even on the hand or the arm.
7) Let the adult know that he/she has the right to refuse to answer all or any questions.
8) Refrain from taking notes during the interview.

Try to obtain a voluntary disclosure by asking focused questions, moving if necessary from the general to the specific. Ask clarifying questions. It is important to know as many details as possible about the abuse.

Use non-verbal means of communication, such as anatomically detailed dolls, anatomical drawings and word or picture cards when the client has a language or speech impairment, is physically or mentally impaired or is too embarrassed to use the necessary words to describe what has happened.

Consider the possibility of both male and female offenders, as well as victims of both genders. Keep in mind that sexual abuse of an impaired adult has frequently occurred multiple times, perhaps by multiple perpetrators and do not regard any part of a disclosure as "confusion," "rambling," "hallucinating" or "embellishing" on the part of the victim.

3-09-06 Legal Intervention in Sexual Abuse

There will be instances in which the Department will petition for custody of an adult based on allegations of sexual abuse. If the Department does not believe removal is appropriate or does not have grounds for taking custody, there may be other legal action which may be taken. One option is to discuss with the supervisor and staff attorney, filing to have a conservator appointed or injunctive relief, such as a temporary restraining order. (Refer to **Section 6, Legal Intervention**)

While prosecution of a perpetrator may be a desirable goal, it is not the foremost goal of APS. Protection and safety of the client must be our primary goal and all avenues must be explored to successfully achieve that end.

3-10 FINANCIAL EXPLOITATION INVESTIGATION - Special Considerations

T.C.A. 71-6-103(j)(4)

When investigating reports of exploitation, the following issues must be considered:

Client's mental/physical capacity to manage own financial affairs.
How client's resources are being used.

Are client's basic sustenance needs being met?
Does another person write checks on the client's account?

When did the alleged exploiter take control of the client's resources and under what circumstances?

Determine whether the client is a willing participant in the exploitation. If yes, determine why the client is willing to be exploited.

3-11 CARETAKERS

The caretaker's role may be the result of an informal agreement, family relationships or life long friendships. We must engage the caretaker and he/she will usually be involved in reducing the risk to the adult client. (Refer to **Section 1-05** and **3-02**.)

1. **Caretakers Who Consent** T.C.A. 71-6-103(f)

APS normally expects caretakers to work with the department in seeking the best interests of the client. As long as the adult or the caretaker consents to APS involvement with the adult client, APS staff are free to **enter any private premises where an adult is alleged to be abused, neglected or exploited in order to investigate the need for protective services**. In cases in which the adult agrees to accept protective services, the caretaker does not have the right to interfere. Generally, it is in the client's best interest for the cooperation of the caretaker to be gained. Such a person is usually in the best position to assist the adult client in improving the client's situation and seeing that his/her basic needs are met.

When APS is able to examine the situation and the relationship of the client and the caretaker, it may be determined that many problems of neglect are brought on by lack of knowledge, lack of resources, stress due to guilt over the client's condition, etc. If the problem can be

identified, then we may be able to make long-term improvements in the conditions which exist may be made. There needs to be empathy for caretakers who are making an effort to "help out" in what are usually very difficult situations.

2. **Caretakers Who Refuse Consent** T.C.A. 71-6-103(f)

If the adult or caretaker does not consent to the investigation, a search warrant may be issued upon showing of probable cause that an adult is being abused, neglected, or exploited. The search warrant will enable the department to proceed with the investigation. If the adult consents but the caretaker refuses to consent to the provision of services, then the court may enter a decree enjoining the caretaker from interfering with the provision of services. (See **Section 6**)

3-12 OBTAINING INFORMATION FROM INDIVIDUALS OR AGENCIES

T.C.A. 71-6-103(j)

The law mandates that department staff involved in **conducting an investigation of abuse, neglect or exploitation of an adult shall have access to the mental and physical health records of the adult** which are in the possession of any individual, hospital, or other facility; **to any law enforcement records or personnel records not otherwise specifically protected by statute, of any caretaker or alleged perpetrator; to financial records that are contained in any financial institution regarding the adult, any caretaker or any alleged perpetrator** when the information is necessary to complete the investigation. **Exception: Drug and Alcohol treatment records may not be released except by court order or with a signed release from the patient.** See Section **3-03** Access to Records and Information.

Other individuals who have relevant information may be expected to share information needed during the investigation based on the requirement to report to the Department of Human Services whenever there is reasonable cause to suspect that an adult has suffered abuse, neglect or exploitation. If known, the report is to include identifying information, the nature and extent of the abuse or neglect, and information which may help to establish the cause of the abuse or neglect. T.C.A. 71-6-103(b)(1). This would apply whether or not the individual was the initial reporter.

If the person does not believe that abuse, neglect, or exploitation of the adult has occurred, then a signed release of information or a court order may be required to obtain the desired information.

If any agency or institution refuses access to these records, the department's attorney should be advised of the situation. The law provides for a motion to the court to ask for an order for the records to be produced. In the case of financial institutions, the department may first obtain an administrative subpoena for the records to comply with the Financial Records Privacy Act (T.C.A. 45-10-101, et. seq.).

3-13 INFORMATION FROM PROFESSIONALS

APS staff are to make full use of the knowledge and skills of other professionals in determining risk to the client, in planning for the client, and in

determining the client's ability or lack of ability to make his/her own decisions. Consultation with other professionals can provide valuable knowledge in determining how dangerous the client's situation is and how urgently change is needed.

A **physician's** examination may reveal a condition that calls for immediate hospitalization, or on the other hand it may be a condition which gives the appearance of serious illness but can be adequately treated in the client's home.

A **psychiatric** examination or consultation may give the counselor a better understanding of the client's behavior and potential for danger to himself/herself or others.

Public and home health **nurses** will often make home visits and assess the seriousness and urgency of the adult's condition.

3-14 SEARCH WARRANT

During the investigation of a referral it is important that we attempt to investigate without seeking court intervention. However, after we attempt to explain the need to investigate, ask for assistance from those who may be familiar with the situation or take other appropriate action which may gain the cooperation of those involved, we may find that all efforts have failed. Court action is then our only alternative. (Refer to **Section 6**)

3-15 PHOTOGRAPHS OF ADULTS

Photographs may be taken of the adult's injuries, or the adult's surroundings when physical evidence of the abuse or neglect is visible on the adult's body or environment. It is important to give proper consideration to the timing and location of the photographs. Photographs should be taken at the point that the adult's condition or the condition of the home or surroundings can be clearly depicted. It may be necessary to take additional photographs of the

adult who sustains additional injuries, or as changes occur in appearance; i.e. color of the injuries, or the conditions in the home worsen.

The following guidelines should be followed when photographs are taken:

- Use color film to ensure that injuries or the home conditions are clearly depicted.

- Each adult photographed should have a visible body landmark in order to identify the adult and the actual location and extent of the area of

  injury. More than one photograph of the injury is generally needed in order to clearly show the landmark and also obtain a clear close-up of the injury.

- Include appropriate identification on each photograph such as: name and age of the adult, date and time of the photograph, and the specific location where the photograph was taken.

Photographs may be taken without the client's consent when the photographs are a part of the investigation, but every effort should be made to enable the client to be comfortable and accepting of the process.

3-16 PHYSICIAN STATEMENTS - FORM 1125

Medical information can be vital in accurately determining an adult's need for services. Most APS clients have medical problems which contribute to their need for protective services. It is, therefore, important to request existing medical information and when needed obtain or encourage the client or caretaker to obtain a new examination/evaluation.

The "Physicians Statement of Need for Court Ordered Protective Services - Form 1125" was developed for use when court intervention is being considered. However, at other times the information on the form may be useful in fully understanding the adult's condition and completing the assessment accurately.

Ask physicians questions like:

What is the client's medical condition?
What treatment is needed?
What is the prognosis with the treatment?
What is the prognosis without the treatment?
What type of care does the client require?
What limitations do they have?

Ask questions which specifically relate to the investigation and evaluation of the need for services.

See Forms, **Section 9**

3-17 TENNESSEE ABUSE REGISTRY

The Tennessee Abuse Registry is a list of persons who have been determined to have abused susceptible individuals such as the elderly or other vulnerable adults. It is maintained by the Tennessee Department of Health. Some agencies and facilities that provide care or services to the elderly, physically/mentally disabled or other individuals who are considered to be vulnerable are required to check the names of prospective employees against this registry before they are hired.

APS staff will have cause to access the Registry list for two different purposes:

1. As part of the investigation of an APS case, to determine whether an individual alleged as a perpetrator has been previously named as a perpetrator.

2. At the conclusion of an APS investigation, to submit the name of a person who was indicated as a perpetrator, when DHS has obtained an injunction against him/her and adds the perpetrator's name to the Registry.

See: **Section 3-17-02—**To Submit a Name to Be Added to the Abuse Registry,

Section 6-13—Injunctions

Section 7—Institution/Facility Investigations

3-17-01 To Check For a Name on the Abuse Registry

Legal Authority

T.C.A. 68-11-1001(b). The names and information contained in this Registry shall be available for public inspection.

The Registry can be accessed by telephone or by Internet.

TO ACCESS THE REGISTRY BY TELEPHONE

1. Method #1 Automated toll-free line.

   a. Dial the toll-free number **1-800-778-4504**.

   b. When prompted **Press 1** for English.

   c. There will be a second message which will prompt you to **Press 2** to check the elderly abuse registry.

   d. **Press 2** and you will be instructed to enter the person's Social Security number. The Social Security number will be repeated back to you to verify its accuracy.

   e. You will receive a response about whether there is any information about the person.

2. Method #2

   You will only use this option when:
   - You do not have the alleged perpetrator's Social Security number, and
   - You do not have access to the Internet.

   a. Call Dorothy Elder at Health Care Facilities, **(615)-532-7534**.

   b. Give her the information that you do have and she will check the Abuse Registry.

Note: The Department of Health asks that this phone contact be used as the last resort if the counselor cannot obtain a Social Security number for the automated line and is unable to get access to the Internet.

TO ACCESS THE REGISTRY ON THE INTERNET

1. Method #1

   a. Connect to the Internet and go to the web site **www.state.tn.us**. This will give you the web page for Tennessee State Government.

   b. From the column on the right, at the bottom section on Directories, select A to Z Contents.

   c. On the A to Z Contents page, select **Abuse Registry.**

d. The Abuse Registry page will provide spaces to insert the name and/or the Social Security number of the person in question.

e. Click on **Submit.**

f. You will be shown the results of your search which will provide information about the individual, or will tell that there is no record based on the information submitted.

2. Method #2

a. Connect to the Internet and go to the web site **www.state.tn.us/health,** which will give you the Department of Health web page. From the choices at the top of the page, select Licensing then click on Abuse Registry to access the **Abuse Registry** page.

b. On this page, there are spaces to insert the person's Social Security number or name.

c. Click on **Submit.**

d. Disciplinary and/or Practitioner Profile Data will be presented with licensure verification results, when applicable.

e. The Abuse Registry page also has links to the:

A. Abuse Definitions,
B. Registry Information page, and
C. Professions Home Page

3-17-02 To Submit a Name to Be Added to the Abuse Registry

Legal Authority

T.C.A. 68-11-1004. The Department of Health shall include the name of an individual on the registry when it receives notification from an agency of Tennessee state government that the individual has been found by that agency, pursuant to the agency's procedures and definitions, to have abused, neglected or misappropriated the property of a vulnerable person who . . . by reason of advanced age or other physical or mental condition, is vulnerable to abuse, neglect, or misappropriation of property, and who was at the time of such determination, in the care of:

(A) A state agency;
(B) An entity which is licensed or regulated by a state agency; or
(C) An entity under the provisions of a contract between that entity and a state agency.

DHS policy states that in order for an individual to be included on the State Abuse Registry, the following conditions must be met:

a. A thorough APS investigation was conducted and has been concluded. The case was found to be valid and there is sufficient information to indicate a specific person of specific maltreatment (A/N/E) of a vulnerable adult.

b. The Department took legal action to seek an injunction to restrain the individual from further contact with vulnerable adult. (See Legal Interventions **Section 6-13** Injunctive Relief.)

c. The court has conducted a final hearing on the evidence and has issued a **final order** in which the person is named as having committed specific act(s) of A/N/E and is ordered to not be in contact with vulnerable adults. This order is separate from and before any appeals of the decision which the indicated perpetrator may subsequently file.

or

The court has conducted a final hearing on the evidence and has **made a finding** that the named defendant in the APS complaint is the perpetrator even if there is no injunction. This finding is separate from and before any appeals of the decisions which the indicated perpetrator may subsequently file.

To submit the name to the registry, send the following information to the APS Program Supervisor for review and submission to:

Dorothy A. Elder, Certification Director
Department of Health, Health Care Facilities
Cordell Hull Building, 1st Floor
425 5th Ave., N.
Nashville, TN 37247

a. a **certified** copy of the final court order (the court clerk's seal must be raised and not a photo copy) in which the indicated perpetrator is named as a perpetrator and as having committed the abuse/neglect/exploitation.

b. the indicated perpetrator's last known mailing address and Social Security number (so that the Department of Health can notify the person of their action to place her/his name on the Registry).

c. the DHS/APS definition of abuse, neglect and/or exploitation which was used in making the determination.

d. the name of the facility in which the incident(s) occurred.

e. the position/role of the person (i.e. nurse, technician, custodian, paid sitter, etc.).

See Sample Letter to Submit Name To Tennessee Abuse Registry in **Section 9** Forms.

SECTION 4 - ASSESSMENT

Checklist

Review information obtained during intake and the investigation.

Assess all areas of potential risk on Case Assessment Form 2861.

Complete evaluation of level of risks.

Determine overall level of risk to the client.

Develop Service Plan (if needed)

Provide Protective Services, reducing risks to client

Complete Case Closure

SECTION 4 - ASSESSMENT

4-01 WHO MAY RECEIVE PROTECTIVE SERVICES - DEFINITION

T. C. A. 71-6-102(2)

Protective services to adults 18 years of age or older; who are unable to protect their own interests due to mental or physical dysfunctioning or advanced age and have no available, willing, and responsibly able person to assist them; and who are abused, neglected, or exploited; or threatened with abuse, neglect, or exploitation.

Need for Services

At the point of assessment, a person must meet the criteria set out in the definition, in order to be determined in need of protective services. Whether or not an adult will receive protective services is based entirely on the adult's "need" for such services. The adult must meet the following conditions:

1. 18 years of age or older;
2. have no available, willing, and responsibly able person to assist him/her and be unable to protect his/her own interests due to:

   - mental dysfunctioning,
   - physical dysfunctioning, or
   - advanced age;

3. and is abused, neglected, exploited or is at risk of being abused, neglected or exploited.

If there is need for translation/interpreter services to ensure effective communication, see **Section 1-10** for procedure to access services. See **Section 1-16** regarding Civil Rights Protections that ensure equal access to benefits regardless of race, age or national origin.

4-02 CASE ASSESSMENT Form HS-2861

The case assessment is to be completed on each case once the investigation of the client's situation is completed. The assessment will give the counselor a clear understanding of the client's needs and whether or not protective services are needed by the client. The assessment is to be done upon completion of the investigation. If the investigation goes beyond a maximum of 60 days from the date the referral Form 700 (HS-0055) is **assigned to the counselor for investigation**, the unusual circumstances must be documented in the case file with the reason for the delay. It is expected that in almost all cases a client's situation will have been investigated, evaluated, assessed, and needed services determined long before the end of the 60 day period.

Once the need for Adult Protective Services has been documented and it is determined that the client is in need of one of the other Social Services Block Grant services, then the additional service may be authorized without regard to the client's income (WRI). The supervisor or District Office will be able to identify those agencies and services in each community which receive SSBG money through a contract with DHS and provide services for APS clients. These services are primarily Homemaker services.

4-03 ASSESSMENT OF THE ADULT'S CONDITION AND CIRCUMSTANCES

The Case Assessment (Form 2861) will be completed using the information obtained during the investigation. The assessment process enables the counselor to review all information and decide the need for services. Completion of the 2861 will identify the information which is known to the counselor, as well as the level of risk for each aspect evaluated.

The assessment process is the point at which information on the client is evaluated. **Each aspect of the adult's circumstances and condition must be evaluated independently** of the other. The level of risk and the strengths of the client will be determined. For example: a client may be very limited in physical functioning, but have a strong support system. Physical health may be considered high risk while an area of strength may be the support system.

The overall case decision may then be that on-going protective services are not required as the client is being well cared for. **Overall risk** combines all components together and evaluates the overall danger to the client in two time frames: (1) prior to APS intervention and (2) following APS intervention.

All areas which impact the client's circumstances and need for protection are pertinent to the decision-making process and are critical in determining the action to be taken by our department.

In general the assessment will consider the following:

Personal Appearance - Age, posture, facial expressions, speech, gait, size, condition and appropriateness of the adult's clothing for the weather.

Physical Health - Problems as identified by the client, medical professionals or observed by the counselor or others (malnourishment, lumps, cough, headaches, sores, pain, bleeding, dizziness, shortness of breath, weight loss, weight gain, vision, hearing, etc.), medications, doctor, last visit to the doctor, etc.

Mental Health - Problems as identified by client, medical professionals or observed by the counselor or others (loss of appetite, insomnia, feelings of worthlessness, hypochondria, suspiciousness, hallucinations, confusion, etc.), use of alcohol or drugs, medications, doctor, last visit, etc.

Client Functioning - Mobility (bedridden, wheelchair, house-bound, yard bound, neighborhood bound, uses public transportation, drives car), **physical/mental abilities—ability to perform activities of daily living (ADLs)** (feeds self, dresses self, uses toilet without assistance, gets out of bed, light house-work, climbs stairs, walks outdoors, cooks, shops, heavy housework), etc.

Household Composition - Relationships and ages

Physical Environment - Neighborhood, remoteness, type of shelter, condition of shelter, utilities, housekeeping, safety hazards

Financial - Income, monetary resources, property, expenses, debts

Social Support Systems (informal) - Known and visited by neighbors and/or relatives, participates in community or other group activities. Availability of family or friends who are willing and able to assist the client and take action when needed.

Community Support Systems (formal) - Identify agencies currently assisting client and the availability of other needed services. Include agencies previously involved and reason services were discontinued.

Caregiver - This will include the person's skill level and willingness to provide care as well as any physical/mental health issues the caregiver is known to have.

Client's Perception of Problems - This will include a statement or discussion of what the client sees as the problem(s).

What the Client Wants - When there are several problems, this may entail the client prioritizing the problems.

Risk to the Client - What dangers exist for the client? Is abuse, neglect or exploitation occurring? What intermediate to high risk factors are present? What do they mean?

Each area to be evaluated contains a list of risk factors ranging from high to strength. These lists should serve to guide counselors in the types of information to obtain and evaluate on the 2861. The risk factor examples are not exhaustive but are to be used as suggestions to assist counselors in assessing and documenting the level of risk to the client. Careful consideration is given to the whole person when critical decisions are made.

4-03-01 Assessment, Form 2861 and Impact on Case Recording

Completion of the Assessment (Form 2861) allows reduced dictation/case recording in APS cases in which only a few contacts are needed. The information obtained and used in decision making must be clearly represented on the Case Assessment. The following elements are important:

1) It must be clear: **where** we obtained the information, **who** provided us with the information regarding the client's condition/situation, **when** and **how** the information was obtained.

2) When we receive or observe conflicting/inconsistent information, it must be clear as to the information provided by each source.

3) Two clients living together should be assessed using individual Assessment Forms.

4) If dictation is not used to identify the method of contact, then those contacts listed on the 2861 need to specify whether these were home visits, phone calls, etc.

4-04 SERVICE PLAN

At the time of assessment the Service Plan will be completed with each client for whom on-going protective services are appropriate. The purpose of the service plan is to give direction to efforts to alleviate or reduce identified problems/risks by specifying actions to be taken and resources to be utilized. The plan needs to be reasonable and appropriate based on the needs of the individual client.

The Service Plan documents the **need for protective services after the investigation.** It must also clearly document the need for each specific service required by the adult client.

When the investigation and assessment are completed the counselor will have determined whether:

1) the reported allegations are valid
2) there are any problems or risks requiring protective services which were not identified in the referral
3) there were any service needs identified during the investigative/ assessment phase
4) appropriate interventions were provided to reduce initial risks identified
5) the client is in need of on-going protective services
6) the client will accept help
7) legal intervention is needed.

The Service Plan is based on:

1) The client's perception of the problem
2) The counselor's perception of the problem
3) The client's motivation and capacity to address the problem
4) The resources available

The client must be involved in the development of the service plan to the extent he/she is able to participate. The counselor and the client may see the problem from different perspectives. The APS perception of the problem should be objective and professional, while the client will be more inclined to "feel" the problem and may be too close emotionally to be objective. The relationship and rapport developed with the client will play an important role in resolving the problem.

When a client is resistant to working on a critical problem, it may be helpful to work on lower priority problems first. Success in resolving the less critical issues may allow the client to feel more comfortable, in control and trusting, allowing APS intervention to address more serious issues.

The service plan should be revised, through Progress Reports, to reflect changes as they occur. The plan is a step-by-step process of problem solving to reduce risks and the provision of an adequate level of safety for the client.

Sometimes a client's situation will require that services be provided during the investigative/assessment phase. If action is taken to resolve an immediate crisis, or to reduce risks identified during the investigative/assessment phase, that intervention should be documented on page 13 of the Case Assessment Form 2861.

4-05 WRITTEN REPORT T.C.A. 71-6-103(d)(4)

The law requires **a written report of the initial findings and a recommendation for further action.** The written initial Case Assessment Form 2861 and service plan will meet the requirements under the law in most cases. However, cases which require legal action will also have the legal referral in the record.

In the event that a client cannot be located and an assessment cannot be completed, the case file should contain a Form 700, an ACSS document, and adequate recorded information on Form HS-2630, Abbreviated Documentation of APS Investigation/Assessment to document the action taken. See **Section 4-16** Abbreviated Documentation of APS Investigation/Assessment.

4-06 PROGRESS REPORTS - REDOCUMENTATION OF NEED FOR PROTECTIVE SERVICES

When receiving services directed toward preventing abuse, neglect and exploitation, the client's need for services must be substantiated by the information contained in the case recording and progress reports.

A Progress Report must be completed within 6 months from the case assessment and at least once every 6 months thereafter. Each progress report will explain the continued need for protective services indicating the changes which have occurred and which services are needed. Progress Reports may be needed in less than 6 months, as they should be completed whenever there are major changes in the client's situation or service needs. (See **Section 1** - General Information)

4-07 FREQUENCY OF PLANNED CONTACTS

Regular contacts must be maintained with the adult client. A minimum of one (1) visit per month is expected. If the need for at least one (1) visit per month is questioned, then the need for on-going protective services would also be considered questionable. **Contacts should be planned and focused according to the needs of the adult client with most clients requiring more than one (1) contact per month.**

Each contact should be made with a definite purpose in mind. The case recording reflects the on-going effort to evaluate and/or reduce risks to the adult client and/or evaluate the adult's continued need for services or changes in service needs.

4-08 PLANNING SERVICES FOR THE CLIENT

There will be situations in which the client's need for protection is clear, such as the critically ill client who is unable to make decisions and has no one to make decisions in his/her behalf. However, a larger proportion of the cases will call for difficult decisions. There is often no clear-cut point at which the client is no longer capable of managing without help.

In serving adults it is important for APS to give as much attention to an adult's capacity for adequate functioning as to his/her incapacities. Remaining abilities need to be preserved and possibly enhanced while preventing, if possible, further deterioration.

The counselor needs to be sensitive, patient, observant, and able to listen and anticipate reasons for a client's response. An angry, insulting client living in a dangerous situation may be a very frightened person. A victim of physical abuse may try to avoid further mistreatment by denying the abuse has occurred. A client who is being sexually abused may relate details of what is happening to someone else or exhibit behaviors which are indicators of abuse occurring. The counselor will need to be on the alert for signs of abuse, neglect, or exploitation. When the counselor has established a meaningful relationship with the client, there is a greater possibility that the situation may be evaluated accurately. If the counselor-client relationship is new, progress in gaining the client's trust may be difficult due to pressure from relatives and/or the community for immediate action to resolve the client's problem or by the urgency of what may be a truly dangerous situation for the client.

4-09 REPORT TO PERSON MAKING THE REFERRAL

T.C.A. 71-6-103(d)(5)

After the investigation is completed and the case has been evaluated, the person who made the referral must be advised of the Department's decision regarding the client's need for Protective Services. The notification may be given verbally or in writing but the record must document that this person was told the Department's decision. This documentation is made on the Case Assessment Form 2861, page 14. The report to the referent should be made when the decision regarding the need for protective services is made. The report should be made on or before the date the Case Assessment Form 2861 is completed.

In practice, this part of the law is helpful in protecting adult clients. People who have reported situations to DHS will know whether APS is actively working with the adult or whether APS has been unable to offer services. An adult who does not need services initially may later find himself/herself in a worsened state and require department intervention. If APS has reported to the person who made the report to APS, then he/she will have a better understanding of the services which can be provided and he/she will be more likely to advise APS of any significant changes in the adult's condition.

4-10 ADULTS WHO REFUSE SERVICES

Adults who have been determined to **need** protective services based on the results of the investigation and assessment may refuse such services. However, reasonable effort should be made to help the adult accept services.

If an adult who is refusing protective services knows their options, is able to recognize the problem, he/she understands and accepts the consequences of refusing services, and **we have made an effort to help them accept services,** then his/her right to self-determination will be respected. Services will be withdrawn. If the adult refuses services and does not appear to have the capacity to make such a decision then legal intervention will be considered. (See **Section 6**, Legal Interventions)

Exception: Mental Health - **Suicidal Client**

Adults who appear to understand that their decisions may result in their death and there are reasons to question their mental status, need to be evaluated by a mental health professional.

Consider the following:

- Adults who appear to be in situations which are not terminal and can be treated or corrected;
- history of suicidal attempts; or
- history of severe depression.

In such cases a mental health assessment and possibly mental health treatment may be needed.

4-11 SAFETY PLANS

Clients who are assessed as living in dangerous circumstances in which abuse has occurred or is likely to occur can be helped in several ways.

Determine the client's willingness to make changes and what he/she wants to have happen. It is common for victims to feel helpless, confused and guilty. He/she may, therefore, need a great deal of support in making positive changes and the change may occur as a slow process.

4-11-01 Removing Alleged Perpetrator

This is especially appropriate when the home belongs to the client.

Discuss options with the client which may include:

- Commitment of a mentally ill perpetrator;
- Protection Order (See Section 6 - Spousal Abuse/Domestic Abuse);
- Refusing to allow perpetrator into home and calling the police;

- Arranging for the perpetrator to see the client when others are present; or
- Identifying other sources of care for the client when the perpetrator provides critically needed care but is also abusive.

4-11-02 Removing Client from Situation

In situations in which the client needs to leave or be removed from the abusive arrangement, considerations may include:

- Assistance in finding other places to live (with relatives, friends, shelters, etc.),

- Assistance in obtaining special care or supervision (residential homes, nursing homes, foster homes, etc.), or

- Court intervention and DHS becoming the decision-maker regarding placement (See Section 6 - Legal Interventions).

4-11-03 Clients Who Choose to Remain in Abusive Situations

Clients who are capable of making their own decisions regarding their living arrangement may decide to maintain their relationship with the perpetrator. In these cases the role of the APS Counselor is to support and encourage clients in taking action(s) which will reduce the risks to them.

One method of doing this is to help them develop a "safety plan" for their specific situation. The plan may include the following:

1. how to get out of the house,
2. a safe place to go,
3. a signal with a neighbor alerting them to the client's danger (a certain light turned on),
4. change locks,
5. call 911 when abuser is on premises,
6. file for an Order of Protection,
7. add "Caller I.D." to telephone,
8. **discuss and identify behaviors of abuser which are exhibited prior to an abusive incident and help the client increase their awareness of these patterns,**
9. **have an escape plan and plan for how the client will respond when they feel threatened,**
10. plan a way to have access to some funds if temporary shelter is needed,
11. maintain or increase contact with family or friend(s) and confide in someone about the situation (do not allow isolation to increase),
12. identify others the client may want to have check on him/her, and
13. identify alternatives for obtaining needed care when the abuser is the caregiver and is violent.

4-13 CLASSIFICATION OF CASES

After the Social Counselor completes the investigation, he/she must organize, analyze, and weigh the investigation information to determine a classification for the report. The classification process includes two (2) steps:

1. Finding relevant information to indicate that the incident or situation did or did not occur and whether or not protective services are needed. Did the alleged incident occur, or does the information indicate that the client is at risk of harm?

   Such information would support a reasonable mind in reaching a rational conclusion and furnishes a reasonably sound basis for the action under consideration. See Section 4-13-02

2. Assigning one of the classification decision types, Valid or Invalid.

VALID CASES:
(1) Case Indicated and Perpetrator Indicated. See section on Release of Identity of Perpetrator (4-14).
(2) Case Indicated and Alleged Perpetrator - Not Able to Determine.
(3) Case Indicated and Perpetrator Unknown.
(4) Case Indicated and Perpetrator Unfounded.
(5) Case Indicated and No Perpetrator.
(6) Indicated Threat of Danger.

INVALID CASES:
(1) Case Unfounded.

4-13-01 **Determining the Classification Type**

The Social Counselor determines the classification type which is subject to the supervisor's review and approval.

1. Determine whether or not the information supports the belief that an incident occurred; or the situation (neglect) exists or existed; or other A/N/E which was not alleged in the referral, was identified during the investigation. If it does then the **case** is **indicated.**

2. If you determine that no evidence supports that maltreatment or self-neglect has occurred, currently exists, or is likely to occur then the case is **unfounded.**

3. If you conclude that an incident has not occurred but, without intervention, there is a substantial probability that bodily harm will occur to the client in the immediate or foreseeable future, then the client is at risk for A/N/E (even if no injuries are present). If a comprehensive risk assessment reveals the impending abuse, neglect, or exploitation then **threat of danger** exists.

4. You must also determine whether or not the information is sufficient to identify a perpetrator. If it is sufficient the **perpetrator** is **indicated.** If it is not sufficient the **perpetrator** is **unknown.** If information is sufficient to show that it is not the alleged perpetrator then the **perpetrator** is **unfounded.**

5. **CLASSIFICATION -** Select the classification that is appropriate for the report.

VALID CASES:

Cases in which abuse, neglect or exploitation has occurred or is about to occur. Action has been, is or will be required to protect the adult client. Those cases which required immediate action prior to fully completing the assessment are valid cases.

(1) **Case Indicated and Perpetrator Indicated -** The information gathered during the investigation established that a client is suffering or has suffered A/N/E. The evidence convincingly indicates the identity of the caretaker or other person(s) who was/is responsible for the A/N/E. See section on Release of Identity of Perpetrator, 4-14.

(2) **Case Indicated and Alleged Perpetrator - Not Able to Determine -** The information gathered during the investigation established that a client suffered A/N/E. However, the information is insufficient to establish whether or not the client sustained harm or injury as a result of the alleged perpetrator's action or inaction. There is not enough information to indicate the alleged perpetrator and not enough information to unfound the perpetrator.

(3) **Case Indicated/Perpetrator Unknown -** The information gathered during the investigation is sufficient to establish that a client suffered A/N/E.

The perpetrator is **unknown** if sufficient information does not exist to identify a perpetrator, nor is anyone specifically alleged to be the perpetrator.

(4) **Case Indicated/Perpetrator Unfounded -** This classification includes cases in which the information gathered during the investigation establishes that a client suffered A/N/E and the information gathered clearly establishes that the person alleged to be the perpetrator is not the perpetrator

(5) **Case Indicated and No Perpetrator -** The information gathered during the investigation established that the client has suffered from situations or conditions resulting in **self-neglect.**

(6) I**ndicated Threat of Danger -** The information gathered during the investigation is logical, relevant, and convincing. There is no bodily harm but currently there is substantial probability that serious A/N/E will occur to the client in the immediate or foreseeable future, given the combination of the following:

- the client's vulnerabilities
- the caregiver's inability, threats or absence
- the lack of a support system.

INVALID CASES: Case Unfounded - The information gathered during the investigation failed to establish that the client sustained harm or injury as the result of the alleged perpetrator's action or inaction; there is no information to support that an incident occurred **or** that neglect or self-neglect exists or existed; and other abuse, neglect or exploitation was not identified during the investigation. A/N/E is not believed to have occurred or to be about to occur.

4-13-02 Specific Classification Guidelines

Listed below are specific guidelines for classification of a report:

General

- Hostility or cooperation on the part of the alleged perpetrator are not deciding factors in classifying reports.

- Although intent is a consideration in the investigation, in the matter of classification of the case, including identification of the perpetrator, intent is not a contributing factor. For the purposes of Adult Protective Services intervention, abuse/neglect/exploitation of an aged/disabled adult may occur even though the perpetrator's intent and belief about his/her action were that the client was safe and receiving adequate care.

- Intent **is** an important factor in problem solving and choosing interventions.

- Do not look **only** for information to support dismissing the allegations **and** do not look **only** for information which supports the allegations. Evidence must be gathered objectively and evaluated in such a way so as to enable a determination of the existence of abuse, neglect or exploitation.

Valid

- The lack of disclosure by the aged person/disabled adult and the denial of the alleged perpetrator requires that corroborative information be sought through collateral contacts in order to resolve the conflict between the allegations of the report and the denial of the abuser;

- The existence of an injury or a mark does not automatically lead to a valid case. It must determined if the injury or mark occurred as a result of abuse or neglect.

- To classify a case as valid there must have been found enough relevant indicators (facts) to prove that the alleged victim suffered the maltreatment.

- If several forms of maltreatment are alleged and the facts obtained do not support that all identified forms of maltreatment occurred, but there are facts that prove that at least one form of maltreatment occurred, **whether or not it was alleged in the referral**, the case is classified as valid.

- To classify a case as **Valid: Case Indicated/Perpetrator Indicated** there must be enough relevant indicators (facts) to prove the alleged victim suffered the maltreatment(s) and enough relevant indicators (facts) to indicate that a caregiver or second party was directly responsible for the abuse, neglect or exploitation.

- To make this determination, the investigator shall apply the appropriate criteria from the following lists:

  (a) the alleged victim asserts that the incident/situation occurred and his/her statements about the allegation(s) are credible and consistent; (an alleged victim's denial of any A/N/E or denial that a second party caused the A/N/E alone should not be the basis upon which a case is closed. Additional information will need to be obtained which either refutes or supports the victim's statements); and/or

  (b) the alleged incident/situation is feasible relative to time and place; and/or

  (c) there is supporting verbal testimony from witnesses and/or others who have knowledge of the incident/situation; and or

  (d) there are physical signs to support the finding; e.g., bruises, injuries, physical indicators of neglect, etc.; and/or

  (e) there is documentation, such as written statements, medical reports, law enforcement reports, incident reports, photographs, bank records, logs, work schedules, etc.; and/or

  (f) there is an admission by the alleged perpetrator that the alleged abuse, neglect or exploitation occurred; and/or

  (g) circumstantial evidence exists linking the alleged perpetrator to the abusive act(s)

  (h) the alleged victim exhibits new or changed behaviors that support the occurrence of the incident/situation; and/or

(l) the allegation(s) conforms to the statutory definition of the report type.

- To classify a case as **Valid: Case Indicated/Perpetrator Indicated** will require that evidence exists which is sufficient to cause a reasonable person to believe that the alleged maltreatment(s) occurred and that a caregiver or second party is responsible for the abuse, neglect or exploitation. See **Section 4-13**, Classification of Cases and **Section 4-14**, Release of Identity of Perpetrator.

Invalid

- Denial by the alleged perpetrator or caregiver is not acceptable as the only rationale for classifying a report as invalid. Collateral information must be obtained. Denial is a strong factor in the makeup of an abuser.

- The fact that the aged person/disabled adult, denies the A/N/E is not reason, by itself, to classify a report as invalid; nor is a change by an aged person/disabled adult from admission to denial. There are many reasons which cause victims to protect their abusers.

- The inability of the aged person/disabled adult to talk, due to any reason, is not justification for classifying a report as invalid.

- The lack of bruises, marks or other physical injury is not by itself justification for classifying an abuse report as invalid.

4-13-03 **Unable to Locate**

Reports in which an investigation is attempted but the client cannot be located, must have documentation in the case file that a diligent search was conducted for the aged person/disabled adult. It should show that:

- Messages were left for them to contact APS;

- Visits were made at different times of the day to the home until either the client was seen and interviewed or the remaining steps were exhausted;

- All available information sources to find them were used; including contacting the person making the referral; and

- Approval was obtained from the supervisor to close the investigation.

4-14 RELEASE OF IDENTITY OF PERPETRATORS TO EMPLOYERS OR LICENSING AGENCIES

Identification of an individual as an indicated perpetrator in an APS case must be handled strictly according to the following guidelines. Release of information about an alleged perpetrator involves issues of civil rights regarding employment. The type of facility will affect the type of information which may be shared. **Release of perpetrator information can take place only following a thorough investigation, assessment and classification of the APS case.**

See **Section 4-14-04** Chart For Sharing of Information After Abuse/Neglect/Exploitation is Assessed.

4-14-01 Actions Prior to Release of Information

1) Prior to releasing information to an employer or licensing agency naming any individual as the perpetrator, counselors must consult with their supervisors.

2) Supervisors will have reviewed the assessment and supporting documentation to determine that the investigation was thorough, and the information obtained and documented in the case record supports the case classification. Poor decision-making could place the counselor, supervisor and the Department in a position of liability and at risk for violating an individual's civil rights. If in doubt as to the validity, field staff should consult with State Office Program staff.

4-14-02 Conditions Under Which Information About the Perpetrator's Identity May Be Shared

1) When the investigation has been completed, the APS case has been determined to be ***valid*** and the perpetrator has been ***indicated***, then his/her identity, **without** any recommendation for action, may be shared with
   - the facility/program administrator and
   - the licensing agency.

2) When the APS investigation establishes that:
   - the case is ***valid,*** e.g. abuse, neglect, and/or exploitation did occur,
   - that there is a perpetrator ***suspected, but not proven*** (perpetrator not able to determine), *and*
   - it appears there is an immediate threat of harm to an individual(s), then information may be shared in the form of "this is where we are in the investigation", "this is what we know at this point in time"; but the suspected perpetrator cannot be identified as the perpetrator.

3) When a joint investigation with another agency is being conducted, then it is appropriate to share information about the suspected perpetrator's identity with another investigator during discussions that arise during the course of the investigation.

4) In cases in which DHS obtains an injunction against the indicated perpetrator, or the court finds the named defendant in an APS complaint to be a perpetrator even if no injunction is granted, then the perpetrator has received due process through the court. His/her name will then be submitted to the Tennessee Abuse Registry. For Injunctive Relief, see **Section 6-13**. For the Tennessee Abuse Registry, see **Section 3-17**.

5) When there is **patient to patient** abuse in a facility, then the identity of the perpetrator may be revealed to the administrator of the facility. Under these circumstances, there is no question of violation of a person's rights to employment.

In most cases, **APS will not make any recommendations about what action the facility should take against the perpetrator**. It is up to the facility and its licensing agency to determine what procedure will be implemented against the perpetrator according to their rules and procedures. In cases involving facilities licensed and operated by DMH/DD, APS is not involved in the investigation. See **Section 4-14-03** Facilities Operated by the Department of Mental Health and Developmental Disabilities below**.**

Releasing information which identifies an individual as an indicated perpetrator of abuse, neglect, and/or exploitation necessitates that the investigation and assessment be **extremely thorough**. No one should be identified as the perpetrator **until the investigation is complete and the resulting information meets the standard of proof** as defined in Section 4-13 that:

a) the alleged victim suffered maltreatment and
b) a specific person(s) was directly responsible for the abuse, neglect and/or exploitation.

See:
Section 3-17 Tennessee Abuse Registry
Section 4-13 Classification of Cases.
Section 4-13-01 Determining the Classification Type.
Section 4-13-02 Specific Classification Guidelines.
Section 6-13 Injunctive Relief

4-14-03 **Facilities Operated by the Department of Mental Health and Developmental Disabilities**

As the result of a change in the law, APS does not have the authority or responsibility to conduct investigations into allegations of abuse, neglect or exploitation occurring in facilities **operated** by DMH/DD. T.C.A 71-6-103(k).

These facilities are specifically:

Arlington Developmental Center
Clover Bottom Developmental Center
Green Valley Developmental Center
Lakeshore Mental Health Institute,
Memphis Mental Health Institute
Middle Tennessee Mental Health Institute
Moccasin Bend Mental Health Institute
Western Mental Health Institute

APS will continue to investigate allegations of abuse, neglect or exploitation that involve residents/patients in these facilities but occur to the residents when they are **outside** the facility; as well as allegation of abuse, neglect or exploitation that occur in other facilities licensed by but **not** operated by DMH/DD as described in **Section 7**.

Information about the identity of the perpetrator as determined by the investigation will be shared with DMH/DD as described above in **Section 4-14-2** and shown in the chart in **Section 4-14-04**.

See **Section 7** for investigations in facilities operated by and or licensed by DMH/DD.

4-14-04 Chart for Sharing of Information After Abuse/Neglect/Exploitation is Assessed

Following is a chart which shows what information may be released to/shared with whom **upon completion of the investigation, assessment and classification of an APS case**. The chart shows release of information in cases involving:

- facilities licensed **and** operated by the Department of Mental Health and Developmental Disabilities
- facilities licensed by the Department of Mental Health and Developmental Disabilities
- facilities licensed by the Tennessee Department of Health
- related boards and the registry operated by the Tennessee Department of Health
- law enforcement and Tennessee Bureau of Investigation
- unlicensed facilities, programs and services
- Adult Day Care

It may be used as a guide for counselors, supervisors and legal staff in decision making on those issues. Particular attention needs to be paid to those items marked with asterisks (*/**). Certain levels of information may be released only when conducting investigations in facilities **operated** by DMH/DD; these facilities are listed on the bottom of the page with the chart. (See next page).

SHARING OF INFORMATION AFTER ABUSE/NEGLECT/EXPLOITATION IS ASSESSED

	What Information Can be Shared			
With Whom We Can Share Information and Under What Circumstances:	**APS Case is Valid**	**Information Obtained during the Investigation***	**Identity of the Perpetrator, but No Recommendation for Action to be Taken Against the Perpetrator ***	**Identity of the Perpetrator in Conjunction with Action to be Taken Against the Perpetrator ***
Investigations in Institutions and Facilities Operated by MH/DD**				
Investigation Conducted Jointly between APS and MH/DD	X	X	X	X
Investigation Conducted Separately by APS and MH/DD	X	X	X	X
Facility Administrators	X	X	X	X
Facilities Licensed by MH/DD				
When Investigation is Conducted Jointly with APS: Licensing Staff, State MH/DD Investigator, DD Community Agency Investigators who are Designated by DDD.	X	X	X	NO
When Investigation is Conducted Separately by APS: Licensing Staff, State MH/DD Investigator, DD Community Agency Investigators who are Designated by DDD.	X	X	X	NO
Facility/Program Administrator	X	X	X	NO
Facilities/ Institutions/Agencies Licensed by TN Dept. of Health				
Investigation Conducted Jointly between APS and TDH Licensure	X	X	X	NO
Investigation Conducted Separately by APS and Licensure	X	X	X	NO
Facility/Institution/Agency Administrator	X	X	X	NO
TN Dept. of Health				
Health Related Boards	X	X	X	NO
Abuse Registry	X	X	X	NO
TBI	X	X	X	X*
Law Enforcement	X	X	X	X*
Unlicensed Facilities	X	X	X	NO
Other Programs/Services which do not Require a License	X	X	X	NO
Adult Day Care				
Licensing Staff	X	X	X	NO
Program Administrator/Director	X	X	X	NO

*Identity of the Referral Source is **not** to be revealed as a part of the information shared. A court order is required. (See T.C.A. 71-6-118)

Memphis Mental Health Institute, Western Mental Health Institute, Middle TN Mental Health Institute, Lakeshore Mental Health Institute, Moccasin Bend Mental Health Institute, Arlington Developmental Center, Clover Bottom Developmental Center, Green Valley Developmental Center **(Information regarding investigations in these facilities is to be shared as directed under the memorandum of Understanding with the Department of Mental Health/Developmental Disabilities.)

4-15 CASE CLOSURES

When

Cases may be appropriately closed when:

A. Case is determined to be invalid, not in need of Adult Protective Services;

B. Identified risks to the adult have been eliminated;

C. Identified risks to the adult have been reduced to the lowest level possible and our continued involvement provides no additional benefits or purpose;

D. Client dies (review may be required, See Section 1-11);

E. Client is in need of APS but refuses services (See Section 4-10);

F. We are unable to complete the investigation as client cannot be located. Document actions taken to locate, including additional contact with the person who made the report.

When cases are closed because goals B. or C. above have been achieved, APS will review whether or not a perpetrator has been indicated, and whether it is appropriate and desirable to seek an injunction against the indicated perpetrator before the case is closed. See **Section 6-13** for uses of Injunctions.

How

- Ensure that the adult is aware of the decision.
- Complete Case Closure Summary, Form 2750..
- Supervisory Approval - See **Section 1-09-01**.

4-16 ABBREVIATED DOCUMENTATION OF APS INVESTIGATION/ ASSESSMENT

Some case situations do not require completion of all elements of the assessment, as structured on the Case Assessment Form 2861. Therefore, Abbreviated Documentation of the APS Investigation/Assessment (Form 2630), may be completed for the following reasons.

1. The allegations regarding the threat of harm are CLEARLY ENTIRELY WITHOUT SUBSTANCE:
   - On initial contact with the client it is observed that the client's circumstances or the environmental factors are clearly different from those alleged, and there are **no other** indicators of threat of harm that suggest there may be a need for protective services.

[Examples: 1.) Allegations of injury due to abuse. There are no injuries whatsoever, and investigation is not needed to determine the cause of the injuries.

2.) Allegations that living conditions are a source of risk. The home is in good condition, and living conditions are readily observed to be appropriate for the adult and without any hazards.] This gives reason to believe the allegations have no substance and are based on misinformation.

- Others who have knowledge of the situation and are credible support that the allegations are obviously without substance and there are no other conditions that create risk of harm.
- There is no information to support the allegations **or other conditions of risk**.
- The only logical conclusion is that the allegations were based entirely on misinformation.

Use of the 2630 **does not apply** to those **cases which require a full investigation to determine that the case is not valid**, **regardless** of the time frame in which the investigation can be conducted.

Some allegations such as sexual abuse, financial exploitation, etc. are unlikely to ever be resolved without a full investigation, because their lack of substance and the need for protective services is not immediately apparent on the surface.

Cases in which any part of the allegations needs investigation to determine their validity are not appropriate for the Abbreviated Documentation form.

2. When the investigation is initiated, the investigation the APS Counselor finds that, without APS intervention, the adult has already been placed in a long-term protective environment and is no longer at risk for the allegations reported.

3. There are verifiable plans for the adult, without APS intervention, to be placed in a protective environment in the immediate future and an appropriate interim plan was established.

4. When the investigation was initiated, the investigation the allegations reported, although accurate, had already been addressed and resolved without APS intervention.

5. When the investigation was begun, it was verified that, without APS intervention, the alleged perpetrator no longer had access to the reported victim or other vulnerable adults and no other risk factors were identified.

6. APS is unable to locate the client following diligent efforts.

7. During the course of the investigation and prior to the completion of the assessment, the alleged victim dies and the counselor was able to verify that the death was the result of natural causes, unrelated to any abuse, neglect or exploitation.

8. Following the investigation, the client appeared to understand the consequences of his/her actions/decisions and refused services.

Required Activities:

The following activities constitute an abbreviated investigation and assessment of a report. **All** of these activities must be completed in order to use the abbreviated documentation form. (Number 6 above is an exception).

A. Adult interviewed and observed. APS counselor must actually see and speak to the adult about the allegations.

B. If the adult is unable to communicate or is incapacitated, reputable persons having knowledge of the situation will be interviewed regarding the allegations.

C. Home visit is needed if the allegations pertain to hazardous home conditions or other issues relevant to the physical living space.

D. Other persons or professionals having knowledge of the situation must be contacted if there is a reason to believe they can contribute relevant information.

E. As with all other APS referrals:
   1). the 1215 must be sent, and
   2). the reporter must be contacted regarding the action taken, **and** to clarify the allegations when the allegations appeared on initiation of the investigation to have been clearly without substance.

If a case is identified by the investigating counselor as fitting one of the case situations in numbers 1 through 6; then they may request approval from their supervisor to use the abbreviated documentation form. **The form must be completed and all required activities must be completed and approved by the field supervisor within thirty (30) calendar days from the date of assignment.**

DOCUMENTATION

These case files will contain the following documentation:

- FORM 700 APS INTAKE REFERRAL FORM
- ACSS INPUT FORM
- ABBREVIATED DOCUMENTATION OF APS INVESTIGATION/ ASSESSMENT, FORM HS-2630

Abbreviated documentation cannot be used for investigations in facilities or institutions unless specified in **Section 7** and in compliance with any existing Memoranda of Understanding.

SECTION 5 - SERVICE PROVISION

5-01 PROVISION OF PROTECTIVE SERVICES T.C.A. 71-6-103(g)

If the **Department determines that an adult is in need of protective services, it shall provide or arrange for the provision of the appropriate services except in cases in which the adult chooses to refuse such services**. Consent of the adult may be given in various ways ranging from outright acceptance to acceptance with much reservation and misgiving. Casework and interviewing skills will be required when the latter acceptance is voiced in order to obtain the participation and cooperation of the adult client. In such cases efforts to provide needed service should continue unless the adult makes a definite decision to withdraw his/her consent. See **Section 5-02** Self Determination below.

In almost all cases we are able to provide services to adults without seeking any sort of court action. Legal action is only used in severe cases as a last resort. See **Section 6** Legal Intervention for policy related to when and how to access legal action.

Most persons in need of protection can be adequately served through the efforts of service workers who establish good client-worker relationships, accurately evaluate the needs of the client, seek and use the help of interested relatives and friends, and effectively use community resources including contract agencies.

Service provision will be based on the plan developed during the Assessment. (See **Section 4-04**, Service Plan).

5-02 SELF-DETERMINATION

Adult clients, regardless of age or condition, have a right and responsibility to direct their own lives to the extent that it is possible for them to do so. This means that each client will:

- be given every opportunity to make plans for himself/herself to the degree possible;
- be given full and honest information about the alternatives and options that are available to assist in making an informed decision.

There may be differences between how the client perceives the problem and the APS assessment. While the client may be unwilling to accept the intervention which the department identifies as providing the greatest safety for the client, she/he may be willing to accept lesser activities which reduce risk and enhance

safety to some extent. In such situations, APS will accept the client's right to self-determination and provide those services which the client will accept. **In no event should such a situation be viewed as a refusal of services.**

Although the principle of self-determination requires that clients be free to make their own decisions, it is the responsibility of the Department to protect the client when the latter's capacity for self-determination is impaired. In providing protective services there may be situations in which the Department will discuss with the client, or those interested in him/her, a plan which the agency believes to be best for the client.

Consideration must be given to the client's strengths, attitudes, coping abilities and the support systems which may or may not be available to him/her.

5-03 RELATIVES AND FRIENDS

If the client is unable to act in his/her own behalf, help of responsible relatives or other appropriate persons should be sought. Their help with planning and their moral support is usually needed by the client. In many cases family and/or friends will be able to meet some of the client's needs and the Department's role will be to provide guidance and support to those helping the client. The Department of Human Services is to assist the client if there is no other available, willing and responsibly able person to do so. In some cases no services from DHS will be needed.

It is critical to have empathy for the families and friends of mentally and/or physically disabled adults who are trying to help the adult. Those who try to help may fall short of what others (including the client) expect. APS recognizes the burden of caring for a friend or family member. There are many demands on the person's time and often his/her money. There are guilt feelings from not being fully able to take care of the situation. There are often bad feelings due to a lack of understanding or incorrect information. In such cases the APS role will be one of support and encouragement, in order to best serve the client's needs. The APS counselor must, however, avoid taking over the vital role of families and friends.

5-04 COUNSELING

The APS counselor may play a critical role in helping to resolve family conflict and in pulling together concerned family members who may assist in providing care or protection for the APS client. When the client's problems include seriously strained relationships with others who play an important part in his/her life, consideration should be given to whether counseling by APS staff or referral

to a mental health center may help the persons involved. They may need help in understanding each other, adapting their behavior to an acceptable pattern, learning to be tolerant of the situation, or learning to let go and accept help from others.

5-05 DAY CARE FOR ADULTS

Day care for adults may be considered if the problem can be contained or controlled by having activities and supervision for the client provided outside the home for part of the 24-hour day.

5-06 IN-HOME SERVICES

If danger for the client is identified and found to be a real threat to the client's well-being and it is determined that the client is in need of protection, then first consideration must be given to the possibility of providing that protection in the client's own home. Such protection may be possible through any one or a combination of the following: medical care, mental health treatment, homemaker services, day care, financial management, chore services, home-delivered-meals or other services. These and any other available resources should be considered as methods of relieving the danger in which the client is found.

5-06-01 Home Delivered Meals

Because of the interdependence between a person's mental and physical conditions, treating one area may have positive effects on the other. Improvement in the physical condition frequently results in improvement of the mental condition. Reviewing a client's activities, nutrition and medication is important in assessing his/her needs. A referral to a home-delivered-meals program may bring about improvements in both physical and mental functioning.

5-06-02 Homemaker Services

a. When and How to Use

Prior to authorizing homemaker services for an adult client, a careful evaluation of the adult's needs is necessary. A complete understanding of the adult's abilities, as well as present limitations, is critical in making appropriate requests for homemaker services.

Generally, a homemaker may assist in situations in which the adult is unable to perform critical household tasks. The homemaker may assume responsibility for light cleaning, planning and preparing meals, marketing, light laundry, and simple bedside care. If the adult is able to perform some household tasks, the homemaker will perform those which are specified

by the counselor and cannot be completed by the adult. If the homemaker observes that the adult is not able to perform some other tasks or if the adult refuses to do what seems reasonable for him/her to do, the problem should be brought to the counselor's attention. The plan for the adult may need to be adjusted.

The homemaker **cannot** administer medication, change dressings, give enemas or irrigate catheters, assist with physical therapy or speech therapy, assist the person in or out of the tub or shower, etc. She/he can remind the adult to take prescribed medication on schedule, assist with personal grooming, assist with bed baths, assist in walking to the bathroom, assist into a wheelchair or other chair, feed the adult, etc.

A referral for homemaker services is not appropriate when the only service needed is transportation. Homemakers only provide transportation when it is in conjunction with other activities which are appropriate under homemaker services.

A homemaker referral may be considered in cases such as:

- an elderly adult living alone who is no longer able to manage some of the basic household tasks;

- a disabled adult who may be dependent on a neighbor to provide needed care and the neighbor moves without notice, becomes ill or dies, or refuses/is unable to continue assisting the adult;

- an ill or infirm adult who is waiting on an appropriate placement (example: residential home for the aged);

- a stressful situation created in a family caring for an infirm adult has led to neglect or abuse, and having a homemaker accept some responsibility for the care of the adult provides needed relief;

- an elderly adult may have lost a spouse and needs training from the homemaker on ways to take care of his/her own needs (example: food preparation).

A counselor requesting homemaker services must be specific as to the tasks he/she believes the homemaker needs to perform. The adult needs to do as much for himself/herself as possible, while the homemaker supplements what the adult, the family and/or friends are able to do. To the extent possible, the adult needs to be included in the assessment process.

b. **APS and Homemaker Services**

When assessing a client's need for Homemaker Service, keep in mind that **the client must meet the criteria for receiving protective services before a protective service homemaker can be assigned.** Not everyone who would benefit from a homemaker is in need of protective services.

Rarely will it be appropriate to have a homemaker accompany the counselor to initiate the investigation. Equally as rare will be those cases in which the need for a homemaker is identified and the offer of such service is made during the initial contact with a client. **The case must be fully assessed as to risk, client functioning and available support systems before homemaker service is included in the service plan.**

After carefully identifying the needs which can be met by the homemaker, the counselor needs to clearly convey this plan to the homemaker provider and assist in implementing the plan. In most cases the counselor will want to go with the homemaker to the adult's home for the homemaker's initial visit. The counselor will continue to have regular contacts with the adult to evaluate the services being provided.

The counselor may need to:

- help the adult avoid over-dependency on the homemaker,
- involve relatives/friends in the care of the adult,
- monitor the progress or deterioration of the adult's condition, or
- help the adult accept the homemaker in the home.

Homemaker Services may be available through any of several different funding sources such as Social Services Block Grant, the Older Americans Act, United Way, etc. It is important that staff in each county understand the role they have in working with various homemaker programs. If needed, the district offices will be able to assist county staff by identifying the Social Services Block Grant services and differentiating between available homemaker contracts.

Knowing the type of contract will be important in determining the appropriate level of involvement for DHS Protective Services staff in initiating and continuing Homemaker Services. It may be helpful for staff to review the Performance Standards for Homemaker Services in the DHS Community Services Programs, Policies and Procedures.

c. **Closing a Case for APS but Continuing Protective Services Homemaker Services**

Under appropriate circumstances, a case may be closed for Adult Protective Services, but continued as a **Protective Services - Homemaker only** case.

Prior to closing the case, the initial Assessment Form (817) and Service Plan (HS-2754) must have been completed, clearly identifying the client's functioning at the time, needs and available support system. Carefully review the levels of risk in each area that was assessed and, in the closing summary (HS-2750), describe how risks have been reduced due to the existing provision of Homemaker Services. Explain the rationale for the case decision that no additional services are needed to ensure the client's safety.

Everyone who would benefit in some way from general Homemaker Services will not need Homemaker Services as a Protective Service. **The client must meet the criteria for Protective Services and the record must reflect the ways in which Homemaker Service will meet all identified protective needs.** If there are other protective needs which cannot be met through Protective Services - Homemaker Services, then the **case must remain open for Adult Protective Services**.

5-07 RELOCATION

Our focus is on protecting the adult and in order to do this we must:

1) determine the level of care the adult client requires and

2) help the adult to understand and accept this level of care.

If it appears that the client needs to move to a different living arrangement due to dangerous physical surroundings, an abusive caretaker or the need for additional care and/or treatment, then it is important for the client to consent. Without the client's consent, a move can be made only by order of the court. An involuntary move is more traumatic for the client than one which is understood and accepted.

Many times an adult will refuse a new idea out of fear or lack of understanding. They may fear a change because they do not know what will happen to them or they may have been given misinformation about a possible placement. In order to encourage change we must deal with the client's fear. A visit to the proposed new residence is often helpful. A chance to see the new location and talk to others without being obligated to stay or to return if they do not want to do so may help.

Even if the client agrees to move to another location a successful move is not guaranteed. The new arrangement may not be all that the client expected; there may be more regrets than anticipated over leaving the old residence; and relationships with others in the new setting may be disappointing, etc. Some moves are more successful than the adult may have expected. They may find the adjustment easier and find greater security in the new location.

A client who is capable of understanding his/her situation may make the decision to continue living in a residence which we believe to be unsafe. When relocation is being considered, the anticipated effect upon the client must be weighed very carefully against the satisfaction the client may feel in remaining in familiar but dangerous surroundings.

Some adults are more appropriate for Adult Family Homes than nursing homes while others require nursing home care. Foster care, as provided in a family setting, is quite different from that of an institution. Many elderly and disabled persons look upon moving into a nursing home, not as achieving care and protection, but as loss of control over their own lives, possibly even a threat to survival.

Also to be considered is the client's ability to cope with change. Keeping in mind that if the client is traumatized by the change, that reaction may be intensified if the adult also feels that he/she has no control over what is happening. It is, therefore, important to support and encourage the client's participation in placement decisions to the greatest extent possible.

If a client with the capacity to understand and make decisions and in need of relocation refuses despite the APS counselor’s best efforts, then APS will continue to provide whatever services the client will accept that serve to reduce risk.

5-07-01 Adult Family Home (Foster Care) Emergency Payment Process

APS can authorize, for up to three (3) months, Emergency -Room and Board payment(s) for Adult Family Home (Foster Home) clients whose income has been used or exploited, and who have no source of income until their next pay check, or until they get approved for SSI, Social Security, etc. The procedure for payment is similar to the regular contract payment process with exceptions as described below.

The Authorization to Vendor Form **and** the 5410 Requisition For Boarding and Special Needs Funds are required for payment and submitted to State Office Fiscal Services:

- All documents are submitted as originals with original signatures (no faxes).
- Keep copies for your files.
- The Authorization to Vendor Form must be submitted each time the contract payment amount changes.
- The 5410 Requisition must be submitted each month that the service is provided.

1. Requisition for Boarding and Special Needs Funds (5410):
   - On Line 1 – Board:
     - In the **Date Service Rendered** column enter the dates that Emergency-Room and Board funds were used.
     - In the **Monthly Rate** column document the monthly rate for Adult Family Home room and board as provided in the current yearly update to **Section 17** Family Homes For Adults.
     - In the **Emergency Shelter (Other)** column enter the emergency funds amount which is the monthly rate prorated by the number of days used that month.
     - In the **Total Amount** column, repeat the amount of the prorated emergency funds.
   - On Line 7 – Payment for Services
     - In the **Date Service Rendered** column, enter the same dates on line 7 as listed in the column on line 1.
     - In the **Monthly Rate** column, document the monthly service fee rate which is a maximum of $200.
     - In the **Total Amount** column, enter the prorated service fee, as prorated by the number of days used that month.

   Note: When prorating amounts, check if the month being documented had 28, 29, 30 or 31 days.

2. Authorization to Vendor Form:
   - **From** (State Agency Name): DHS – Adult Protective Services
   - **Program**: Adult Protective Services—Adult Foster Care
   - **Cost Center**: APFC
   - **Allotment Code**: 345.49
   - **Pursuant to DPA #**: Contact State Office to obtain the number of the DPA contract for the current fiscal year.
   - **Vendor**: Document sponsor's information in these areas.
   - **Items Authorized**: Enter APS client's name on the top line
     Enter Emergency Room and Board in the next space
     Enter Payment for Service in the second space

- **Dates of Service**: Enter the dates as shown on Form 5410.
- **Units Authorized**: Enter number of days if less than a full month, or one month.
- **Unit Cost**: Enter the prorated amounts each for room and board and for service, or enter monthly rates if for a full month.
- **Amount Authorized**: Enter the total amount for board and service; it will match the figure in the Total Amount column on Form 5410.
- **Effective Date**: Enter the starting date on the placement contract.
- **State Agency Authorization**: APS staff signature, title and date.
- **Vendor Acceptance**: The sponsor's name and signature as they appear on the placement contract, date.

Procedures for placement of the APS client in an APS Adult Family Home are described in **Section 15** Family Homes For Adults.

APS continues to have an exemption which authorizes state employees and officers to provide Adult Family Home (Foster Home) Services. If the sponsor is a state employee or officer, the placement contract will include Attachment #1 To HS-0071-Adult Placement Contract.

Updates/rate changes occur annually and new information should be incorporated as appropriate.

5-07-02 Hospitalization

There may be times when the client's condition, physical or mental, indicates a need for medical care, including hospitalization. The ***Diagnostic Related Group*** (DRG) is a uniform code for reimbursement used by hospitals to categorize patient admissions. In some situations, the client may be able to receive care as an outpatient, or the hospital is ready to discharge the client, but there is no safe placement immediately available. It may be possible to use an appropriate DRG to gain admission to the hospital or extend the client's stay for a limited period to allow enough time for the APS counselor to arrange for an appropriate resource or implement an intervention to ensure the client's safety. It is important for APS staff to be aware of this option and of codes that may be used to permit the client's hospital stay so that staff:

- will recognize hospitalization as an option for temporary safety;
- may be able to knowledgably discuss this service with medical staff as part of planning for the client's safety.

Following are some of the codes that can be used to admit clients from unsafe environments:

"Adult Maltreatment Syndrome"

DRG # 454 – Ages 70+, injury/toxicants with complications
DRG # 455 – Ages 18 to 70, without complications

"Decubitus Ulcer"
DRG # 271 – Skin ulcer, multiple etiologies

"Malnutrition"
DRG # 296 – Age 70+, with complications
DRG # 297 – Age 18 to 70, without complications

There may be other DRGs that are applicable to gain temporary hospital admission for the client's safety.

5-08 RELOCATION TO UNLICENSED FACILITIES IS PROHIBITED

The counselor cannot assist the adult in moving to an unlicensed long-term care facility. The Tennessee Department of Health has the legal responsibility for the licensure and regulation of long term care facilities. If APS assisted in placement of an adult into an unlicensed facility, APS would be aiding in the violation of the law. Furthermore, the provider of care might feel compelled to accept the adult if DHS staff were involved with the placement. They could then be operating in violation of the licensing law.

The counselor may need to assist adult protective services clients or their caregivers in locating and/or making application for admission to licensed long-term care facilities. Information included in **Section 7** Institutions, will facilitate the process of assisting the adult in locating a long term care facility and placement in such a facility.

5-10 DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES COOPERATION WITH DHS T.C.A. 71-6-113

The Department of Mental Health and Developmental Disabilities shall assist the Department of Human Services in the provision of protective services.

> "When the Department of Human Services is unable to find a resource for any person in need of protective services who because of mental illness or developmental disabilities, is in need of specialized care or treatment, the Department of Mental Health and Developmental Disabilities shall give priority to such person for appropriate placement."

The law specifically requires the Department of Mental Health and Developmental Disabilities to assist DHS in any way possible to provide services required under the Adult Protection Act. MH/DD is required to report incidents of abuse, neglect or exploitation to DHS and give information relevant to the

reported incident when those incidents occur outside the state operated facilities. APS has access to the MH/DD records when such information is necessary to complete the investigation. An exception to the APS access to mental health records is those records of alcohol and drug treatment. Access to those records requires a release of information signed by the patient or a court order granting access.

TDMH/DD is required to give priority for an appropriate placement to a person in need of specialized care or treatment due to mental illness or mental retardation who is also in need of protective services. This does not mean that they will accept any protective service client we refer to them for placement in an institution. However, if the client is in need of protective services and needs treatment at a MH/DD facility, that department is required to accept the client for appropriate placement before they accept other clients who may be waiting for admittance. See T.C.A. 71-6-113(b).

The Commissioners of the Departments of Mental Health/Developmental Disabilities and of Human Services and the Division of Mental Retardation Services have developed a procedure for resolving any impasse that APS may encounter when a need arises for mental health or mental retardation services for APS clients. This process is to be used to notify DHS-APS State Office when:

> the effect of any action or inaction on the part of a facility or staff of the Department of Mental Health/Developmental Disabilities or of the Division of Mental Retardation Services is to put an APS client at continued risk or at greater risk.

In the event of any such situation which, cannot be resolved at the local level in a timely manner to ensure the safety and protection of the APS client, the supervisor will be notified of the situation. APS state office will then be notified using the form *Adult Protective Services Request For Assistance/Department of Mental Health/Developmental Disabilities or Finance & Administration – Division of Mental Retardation Services*. The form is available from the APS supervisor as either an electronic or a handwritten form, or can be requested from State Office. It is preferred that the electronic form be used because of the capability of the expandable fields to capture all the information about the client's situation. The handwritten copy should be printed for use when access to the computer is unavailable and the situation needs to be addressed quickly. When completed, the electronic or handwritten form should be e-mailed or faxed to the state office. APS state office will then take steps to intercede and request the assistance of MH/DD or DMRS staff at the state level to resolve the situation.

This notification process also applies when any mental health staff refuse to provide access to their records during an investigation, excluding alcohol and drug treatment records which are protected by federal statute. The request for assistance form is used to document the situation.

This notification process to MH/DD and/or DMRS will not delay any APS investigation that may be in process or other efforts to reduce risk to the APS client, but will serve as a uniform way to respond when APS has been unable to access specific needed services for APS clients from these agencies.

For procedures related to access of crisis team services in situations needing mental health, developmental disability or mental retardation assessment and/or intervention, see **Section 5-17** Use Of Mental Health Crisis Teams.

5-11 TENNESSEE DEPARTMENT OF HEALTH COOPERATION WITH DHS

T.C.A. 71-6-113

The Tennessee Department of Health shall assist the Department of Human Services in any way possible with provision of protective services. Refer to Section 7, Institutions.

5-12 LAW ENFORCEMENT COOPERATION WITH DHS T.C.A. 71-6-115

Law enforcement officials shall cooperate with the Department of Human Services in the provision of protective services. Further, when DHS has custody and is unable to return an adult to physical custody who voluntarily leaves such custody, law enforcement shall assist in returning the adult to such physical custody and shall give priority in providing such assistance.

5-13 NURSING HOME PLACEMENTS

5-13-01 Nursing Home Waiting Lists

This information on nursing home waiting lists pertains specifically to nursing care facilities that participate in the medicaid program. Nursing homes are required to maintain a waiting list of persons requesting admission to the facility. The waiting list must include the applicant's name, address, telephone number (if any), sex, race, date and time of application, and the person or agency referring the applicant to the facility.

Generally, admissions to nursing homes are made in the order the referrals were received. Deviations from the order of application may be made when the deviation is based on medical need or other exceptions approved by the Department of Health. The nursing care facility will have a letter from the TN Department of Health indicating approved deviations.

To expedite the application process for admission to a nursing care facility it is important to keep in mind that referrals received from the Department will be handled in the following manner:

1. Applicants shall be placed on a waiting list without formal application until they are within sixty (60) days of admission to the facility, based on the facilities experience with admissions.

2. When the applicant is within 60 days of admission to the facility as estimated by the facility, the facility shall notify the applicant and the Department of Human Services in writing so that a formal application can be made prior to consideration for admittance.

3. If after forty-five (45) days from the date notification is issued the facility has not received a completed application, the facility may then remove the applicant's name from the waiting list.

5-13-02 Emergency Nursing Home Placements for Adult Protective Services Clients (Exception)

A nursing home facility is required to accept applicants in the order in which the referral or request was received by the facility. One exception for deviation from this rule is "emergency placements requested by the Adult Protective Services of the Department of Human Services."

The Tennessee Department of Health recognizes that APS clients who are in a critical condition or situation may require emergency placement in a nursing home. The APS counselor has the ability to request that a client be moved up on the waiting list for placement. This in no way affects other admission requirements.

In order for an APS counselor to use this "emergency" placement exception, the case record must clearly document the need for protective services which has been established through an investigation. The investigation, by law and policy, must include a face-to-face interview with the adult reported to be in need of placement. For clients **who need nursing home** care a counselor may consider the use of the emergency placement exception in situations in which:

(a) A client has been abandoned by a caregiver and there is no other responsible party available.

(b) A client is unable to care for him/herself, the caregiver is incapable of providing the level of care necessary to prevent serious harm to the client or his/her condition may be life threatening.

(c) A client is a victim of physical abuse or sexual abuse and the perpetrator will not leave the home or there is no other caregiver available.

Caution must be exercised when requesting an "emergency" placement which requires by-passing other applicants to a facility. Adult Protective Services counselors need to guard against becoming a community funnel for expedited access to nursing homes. However, legitimate APS clients in dangerous circumstances will benefit from this exception.

5-13-03 Third Party Signatures

A nursing home cannot require a third party signature, as a condition for admission to the facility, for a medicaid or medicare recipient. A nursing home may require a third party signature for private pay patients. Also, any person appointed by a court to serve as the conservator or guardian of an adult may be required to sign the application for admission. Most nursing homes will request information regarding the patient's next of kin and/or the person to contact in the event of an emergency. However, obtaining this information is different from signing an application for admission and assuming financial responsibility.

When the Department has custody of an adult who is placed in a nursing home or other long-term care facility, the counselor cannot sign any form(s) which would make the Department financially responsible for the costs of the adult's care. At the custody hearing, a **temporary guardian** may be appointed to handle the adult's finances.
T.C.A. 71-6-107(a)(6)

If the counselor is unable to convince staff of the nursing home that a third party signature is not required for a medicare or medicaid recipient, the Long-Term Care Ombudsman or the Patient Care Advocate may be able to assist with this problem. (See **Section 11**)

5-13-04 Emergency Approval of Pre-Admission Evaluation (PAE)

A pre-admission evaluation (PAE) is required for medicaid reimbursement to intermediate care facilities. The PAE provides information needed to determine the client's **medical need** for nursing home care. The PAE must be completed, signed by the adult's physician and approved by the Tennessee Department of Health, TennCare/Medicaid staff in order for there to be medicaid reimbursement for intermediate nursing home care.

A system for emergency approval of PAEs has been in place since July, 1985. There continues to be a system which allows us to obtain approval of PAEs in emergency adult protective case situations. The regular process for PAE approval in some cases may require too much time, since the completed PAE application normally must be mailed to TDH, Bureau of Medicaid for processing.

Some situations which may justify using the emergency PAE approval system include those cases in which an adult who requires nursing home care is in

significant risk/danger if such a placement is not arranged immediately and the delay caused by using the regular PAE procedure would significantly increase the risks to the adult. Such circumstances may include those in which the adult is in danger of death, the primary caretaker becomes incapacitated or abandons the adult, or the adult is a victim of physical or sexual abuse by the caretaker.

The emergency approval system requires the following action:

1. The PAE Unit in the TennCare/Medicaid must be called and advised of the situation. Call Pat Santel, Director, Long Term Care, or Koral Cooper, Nurse Manager at (615) 741-0212. If they are not available, ask to speak to one of the PAE Nurses. Their direct numbers can be found in Appendix **Section 11-09** Emergency Telephone Approval of Pre-Admission Evaluations (dated 3/05), or call (615)-741-0212 and ask the operator who answers to speak to a PAE Nurse.

2. The completed PAE must be faxed or mailed overnight express to the PAE Unit. The FAX number is (615) 532-9140**.** Please flag by putting Adult Protective Services at the top. If it is necessary to pay for the fax, the expense may be submitted on a travel claim or on a memo and invoice to the Assistant Commissioner for Adult and Family Services requesting reimbursement.

3. The decision regarding the approval will be made by Medicaid Bureau staff in Nashville. APS can advise the nursing home of the decision regarding the PAE. The nursing home will also need to be notified whether the client has been approved for TennCare/Medicaid. Determine whether the client has TennCare/Medicaid or if an application has been completed.

   Note: If the client's history includes mental illness and/or mental retardation, the PAE approval unit may be required to submit the PAE to the Department of Mental Health/Developmental Disabilities for a Pre Admission Screening and Annual Resident Review (PASARR) to determine the appropriate facility for the client's placement. In that event, it may take up to five (5) days to receive a response on approval of the PAE.

4. The completed PAE should be immediately mailed to the PAE Unit of the Medicaid Bureau Office as follow-up to the faxed copy. Write a notation on the PAE stating the date it was faxed and approved.

The emergency system is **not** to be used as an alternative to the regular PAE procedure; therefore, it should only be used in emergency case situations.

5-13-05 Overbedding - Waivers to Exceed Licensed Bed Capacity

A nursing home must be granted a waiver by the Tennessee Department of Health to go above their licensed bed capacity. The nursing home must have the

capability and willingness to go above their licensed capacity. In some instances overbedding may be used in conjunction with the PAE emergency approval procedure, or it may be used in an emergency situation in which a PAE has already been completed and a nursing home bed cannot be found.

When the counselor is unable to locate a nursing home bed near the client's home, nursing homes within a twenty-five (25) mile radius should be checked to determine whether or not one is willing and also has the potential to overbed. Nursing homes which are located across county lines should be checked if they are within the twenty-five (25) mile radius. In the event a nursing home which will overbed cannot be located within the twenty-five (25) mile radius, the Tennessee Department of Health Administrator may be contacted for assistance in locating a nursing home within the area which may be able to provide care for an additional patient.

The nursing home which agrees to overbed must continue to meet requirements such as: maintaining the correct staff to patient ratio; ensuring that there are not any risks to the client or other patients; and having a bed with adequate and appropriate space and a call light.

The procedure to follow to request approval for overbedding is as follows:

- The request for overbedding must be made to the Division of Health Care Facilities, Regional Administrator in the Tennessee Department of Health, Regional Office. These offices are located in Jackson, Nashville and Knoxville. (See Appendix D.)

- The Regional Administrator or the designee will contact the appropriate State Office Director, the Director of Health Care Facilities or the Medical Director can convey information regarding the need for approval to overbed.

- The decision giving the nursing home approval to overbed will be made by one of the State Office staff persons stated above.

  Note: If the client is a Medicare patient, Medicare will not pay unless the patient is placed in a designated Medicare bed.

Overbedding should not be lightly considered; however, when there is a need for an Adult Protective Services client to be placed immediately and a nursing home bed is not available, overbedding should be explored.

5-14 PATIENT CARE ADVOCATE

A Patient Care Advocate is located in the Tennessee Department of Health in Nashville. (See Section 11-04)

The Patient Care Advocate may work with staff in Adult Protective Services primarily in five (5) areas including:

- abuse/neglect cases in long-term care facilities when the Health Care Facilities staff is involved and request the assistance of the advocate;
- adults requiring long term care are inappropriately placed;
- problems and concerns with Pre-Admission Evaluations (PAEs);
- medicaid discrimination matters; and
- financial problems of adults in long-term care facilities.

The abuse/neglect referrals within long-term care facilities will continue to be made to the Health Care Facilities staff. They will in some instances request the involvement of the Patient Care Advocate in the provision of protective services in these abuse/neglect case situations. When there is a long-term care situation not involving abuse/neglect, in which the assistance of the Patient Care Advocate is needed, the referral should be made to the Director of Patient Care Advocacy.

5-15 LONG-TERM CARE OMBUDSMAN

Each of the nine (9) Area Agencies on Aging contract for a Long-Term Care Ombudsman: **Section 11, Appendix 11-08**, lists the Ombudsmen; agencies in which they are located; addresses and telephone numbers of the agencies; and counties served by each office. Ombudsmen are located in: Johnson City, Knoxville, Chattanooga, Cookeville, Fayetteville, Nashville, Martin, Jackson and Memphis. The Ombudsman works with patients and their families facing barriers to long-term care. These adults may be in nursing homes, as well as board and care facilities. The Ombudsman can play an integral and vital role with the DHS counselor and the Adult Protective Services client, because of their ability to investigate and resolve complaints made by and on behalf of older persons who are in Long-Term Care Facilities. They are able to work with these adults on concerns relating to administrative actions which may adversely affect their health, safety, welfare and rights.

The Ombudsman is able to address various problems faced by residents of long-term care facilities ranging from: unsatisfactory food; unexplained extra charges; involuntary transfers; discharges predicated on source of payment or changes in level of care; discriminatory practices at admission; and early release from hospitals due to DRGs (Diagnostic Related Groups) and the placement problems of the adult not well enough to return home. The Ombudsman should be contacted when there are problems or concerns in which they might assist in arranging for or providing protection of an older adult in a long-term care facility.

5-16 PUBLIC GUARDIANSHIP FOR THE ELDERLY PROGRAM

The Public Guardianship for the Elderly Program was established in 1986 by the Tennessee General Assembly. The primary purpose of the program is to provide conservatorship services to persons sixty (60) years of age and older, who are unable to manage their own affairs, and who have no family member, friend, bank or corporation willing to act on their behalf. This service is available in all 95 counties of the state, through the district public conservators located in the nine (9) Area Agencies on Aging. As a less restrictive measure, power of attorney services may be offered by the local programs.

The clients served through the district public conservatorship programs may be unable to make decisions regarding their finances or needed medical care. Frequently they need assistance in obtaining the basic necessities of life. District public conservators help clients by providing assistance which enables them to remain in the least restrictive environment, while preserving personal dignity.

There are no charges for the services provided through the Public Guardianship for the Elderly Program. However, the court may award a fee to the program whenever the resources of a client indicate this to be appropriate. In no instance does a client who meets SSI low-income standards pay a fee. When the services of the Public Guardianship for the Elderly Program are deemed appropriate by the District Public Conservator, an application form will be required prior to acceptance into the program. The form is completed by the person who is requesting the service. For location see Appendix, Section 11-10.

5-17 USE OF MENTAL HEALTH CRISIS TEAMS

Where are MH/DD Crisis Teams available?

Crisis Teams are available to all of Tennessee's ninety-five counties. A listing of the MH/DD Crisis Teams can be found in section 11-12.

What is the appropriate role of the Crisis Team?

The Crisis Team should be called in a psychiatric emergency to make the decision as to whether hospitalization or in-patient stabilization is necessary. Referral to the Crisis Team should be made when a mental illness crisis is <u>suspected</u> and should be based on the behaviors an individual is <u>currently</u> exhibiting i.e. homicidal, suicidal, hostile, aggressive, threatening, responding to stimuli others can't hear or see, or disorientation (due to mental illness) to the extent of endangerment to themselves or others.

How will the Crisis Team respond?

There is no statewide uniform response procedure. When calling to make a referral, ask for the team's procedures to assess for treatment. The Crisis Team may come to the client or they may request that the individual needing assessment come or be brought to them. There may be some situations when the client's condition or, in the interests of an accurate assessment, it is preferable or necessary that the client be assessed in his/her own environment. If the team refuses, the process described below in **"If the Crisis Team declines to assess the individual for treatment, what recourse can be employed?"** may be used to address the problem.

What information does the Crisis Team need when asking to provide help?

The Crisis Team is being asked to assess the individual for treatment. They need to be given the details of why a mental illness crisis is suspected. Describe the behaviors the individual is currently exhibiting. If known, brief behavioral and family mental illness history should also be shared with the team. (History of mental illness behaviors, treatment, medications, alcohol and drug abuse, etc.)

If the Crisis Team declines to assess the individual for treatment, what recourse can be employed?

The functions of a Crisis Team are specifically defined by MH/DD. To insure that appropriate referrals are made, it is advisable for field staff and the local Crisis Team to discuss referral scenarios (with case examples) before a crisis referral needs to be made. Any concern about the response of a Crisis Team should be brought to the attention of the executive director of the local mental health center. If the issues cannot be resolved at the local level, and the individual and/or you remain in danger, request assistance from state office staff as follows:

- If the Crisis Team refuses to assess the APS client in his/her own environment when this is needed to determine the extent of risk or to determine capacity;

- If the Crisis Team refuses to use "(C) unable to avoid serious impairment or injury from specific risks" as a criteria for involuntary treatment;

- If any MH staff refuse to provide access to records during an investigation, excluding alcohol and drug treatment records as noted in **Section 5-10**;

- If there is need to document APS requests for assistance with the client who has dual diagnosis of mental illness **and** mental retardation, and the crisis team is not responding appropriately.

Use the form *Adult Protective Services Request For Assistance/Department of Mental Health/ Developmental Disabilities or Finance & Administration – Division of Mental Retardation Services* as described in **Section 5-10.**

If you feel there is imminent danger to the individual, yourself or others **do not wait; call the police!**

SECTION 6 - LEGAL INTERVENTION

6-01 DECISION TO TAKE LEGAL ACTION

There are several options under the Tennessee Adult Protection Act which allow the Department to pursue court intervention in order to complete an investigation of an APS referral and in order to provide protection to adults who are determined to be in need of protective services.

These options include the following:

. Search Warrant

. Injunction

. Mental or Physical Examination, Only

. Non-Emergency Order or Order to Grant Authority to Consent to Services

. Emergency Order or Order to Grant Authority to Consent to Medical Examination, Treatment and/or Placement - custody

The above stated options should be carefully considered before withdrawing from an investigation or terminating services in any case situation in which an adult is thought to be in need of protection but does not consent or withdraws consent for service.

The options for **court intervention which are in the Adult Protection Act are available only to Department staff with two (2) exceptions**. These exceptions are the following:

Emergency Petitions Filed by a Non-Profit Agency T.C.A. 71-6-107(a)(7)

- A private non-profit agency representing disabled adults may petition the court under the emergency provisions in the law. There is further discussion of this provision in this section.

TN Department of Mental Health/Developmental Disabilities Standing to Petition the Court Using the Adult Protection Act T.C.A. 71-6-103(k)(1)
Refer to Section 7-11

- The Tennessee Department of Mental Health and Developmental Disabilities has standing to petition the court under the Adult Protection Act on behalf of a patient or resident of a facility owned or operated by

TDMH/DD when there is an adult abuse, neglect or exploitation situation in which the department needs legal intervention to protect the adult.

The decision to take legal action is made as a last resort after all considerations have been taken into account and all practical alternatives have been exhausted. There must be a full understanding of the client's condition and availability of resources to meet the client's needs. We must be sure that intervention by all relatives and friends has been explored. If legal action is determined to be needed and justified, we will ask for legal intervention at the least restrictive level which will protect the client.

The more drastic and intrusive the legal action requested, the more severe the client's condition must be.

The Department's only access to the Court is through legal staff. All petitions must be prepared by the DHS staff attorney, both for emergency and non-emergency situations. There are no form petitions or orders which can be used in Adult Protective Services by counselors or supervisors. The decision to refer the situation to DHS legal staff for initiation of legal action is to be made jointly by the counselor and the supervisor.

6-01-01 Standard of Proof

A “substantial and material “level is used in deciding whether or not an adult needs and will receive Adult Protective Services. However, when legal intervention is requested a higher standard is required. A **preponderance** standard is used in the Adult Protection Act. The DHS attorney will determine whether or not adequate proof exits to pursue legal intervention.

If criminal action is considered by law enforcement they are required to meet the highest standard **beyond a reasonable doubt**.

6-02 PROVISION OF PROTECTIVE SERVICES WITHOUT THE CONSENT OF THE ADULT T.C.A. 71-6-107

If the Department determines that an adult is in need of protective services and lacks capacity to consent to protective services, then the Department may file a complaint with the court asking for an order to authorize the provision of protective services.

6-03 COURTS OF JURISDICTION T.C.A. 71-6-114

The law gives the chancery, circuit and general sessions courts jurisdiction in cases filed under the Adult Protection Act. In Shelby County the probate court may also be used.

In cases in which the department must present a petition for emergency removal of an adult and a chancellor or circuit judge is not available, the department may present petitions to judicial officers with general sessions jurisdiction. Further proceedings shall be conducted in chancery or circuit court. T.C.A. 71-6-107(a)(1)(B)

In practice the chancery court is the court of preference (first choice) unless the chancellor is not accessible and there is need for an emergency order. When the chancellor is not readily available and a delay in obtaining the order puts the adult at increased risk then circuit court will be used. General sessions court may be used only in emergencies when the chancellor or circuit judge is not available.

Probate court may be used in Shelby County (775,000 population counties) when the delay created by using the other courts would increase the risks to the adult.

Venue - A proceeding may be commenced in the county where the adult resides or is physically present.

6-04 COURT ORDERED MENTAL OR PHYSICAL EXAMINATIONS - ONLY T.C.A. 71-6-103(l)

This provision is to be used in those cases in which there is **probable cause to question an adult's capacity to consent or there is reason to believe the adult may be in imminent danger** but the evidence is inadequate to petition the court asking for an order to consent to placement, treatment or other services. However, the degree of incapacity or impairment is such that it is reasonable to believe that an examination/evaluation is needed. The purpose of such an order is to provide sufficient information to determine the risks to the adult and the need to petition for an order for placement, treatment or other services.

"Probable Cause" as used in this section means that the factual circumstances in which the adult is found are such as to make a reasonable person believe that it is more likely than not that the adult lacks the capacity to consent and is being abused, neglected or exploited.

If a mental and/or physical examination of an adult is needed in order to determine whether or not the adult is in imminent danger or lacks capacity to consent to protective services, the court may require by court order an examination of the adult to determine whether or not such conditions exist. This type of legal intervention provides for a minimal level of intervention, but enables additional, needed information to be obtained. This is particularly critical when potentially life saving decisions need to be made. **These orders**

provide for examination only and do not permit treatment or placement of an adult without first obtaining an additional order from the court.

The adult may be hospitalized for the **examination(s) only**, in those situations when the needed examination(s) requires the adult to be hospitalized.

In many instances the information may already be available which will enable us to make a reasonable decision regarding either the adult's capacity to consent or to make a decision regarding whether or not the adult is in "imminent danger". When such information is already available on one of these conditions but not on the other condition, then we may request court authority to obtain the examination/evaluation needed to give us the additional information.

Orders for examination may be obtained under the following conditions:

- APS must be investigating the abuse, neglect or exploitation of the adult;

- APS must be able to show probable cause that the adult lacks the capacity to consent to protective services and is being abused, neglected or exploited;

- If an order for a medical examination is to be requested, information must be available which indicates that the adult may be in imminent danger of irreparable harm. Information may be obtained by the counselor's observations of the adult with unexplained, untreated illness or such information may be available from records or contacts with those having knowledge of the adult's condition.

6-04-01 **Types of Orders for Court Ordered Examinations**

- Orders to require the adult to be examined by a physician;
  a psychologist in consultation with a physician; or
  a psychiatrist to determine either the adult's capacity to consent and/or whether the adult is in imminent danger of irreparable harm.

- Orders may be issued without the adult receiving notice or being present (ex parte) by affidavit or sworn testimony if there is cause to believe that the adult is in imminent danger and that delay for a hearing would be likely to substantially increase the adult's likelihood of irreparable physical or mental harm, or both, and/or the cessation of life.

6-04-02 Payments for Court Ordered Examinations

It is expected that the adult will pay the cost of the examinations or any available insurance, Medicare, TennCare or indigent medical services will be used.

When there are no other options and the examination is necessary then the Department may be billed at the Medicaid rate for the exam. Prior to arranging for an examination read **Section 11, Appendix 11-02** for instructions on arranging and paying for examinations.

6-05 EMERGENCY COURT INTERVENTION BY DHS T.C.A. 71-6-107

6-05-01 Necessary Conditions

The law provides for **emergency** court intervention when an adult who is in need of protective services:

a) lacks the capacity to consent to the needed service, and is

b) in imminent danger of irreparable harm and/or death without the service, or

c) is being sexually abused based on sexual activity or contact.

Conditions for emergency intervention may exist when the investigation is initiated or they may develop in a case which is long-term. Whenever such conditions occur or are believed to exist, supervisory consultation should be obtained.

Any time there is reason to question whether or not an adult is in imminent danger, careful review of the adult's capacity to make decisions must be made. In order to determine whether or not legal intervention is warranted, counselors must always obtain supervisory and legal consultation regarding the adult who is refusing life saving services.

6-05-02 Procedures

When the Department makes the decision to seek emergency court intervention the DHS attorney shall always draft the petition to file with the court and the following action will be taken:

a) The Department will file a complaint with the court for an immediate order authorizing the provision of protective services necessary to prevent imminent danger or sexual abuse;

b) The chancellor or judge will hear the complaint ahead of any business then pending in the court or in chambers;

c) The chancellor or judge, prior to entering the order, must find the adult is in imminent danger of harm or is being sexually abused if he/she does not receive protective services and that he/she lacks the capacity to consent to protective services.

d) Within seven days (calendar days, if the 7th day falls on a weekend or holiday it will be the following day) or up to 15 days, for good cause shown, of entering such an order, the court must hold a hearing on the merits of the case. If the hearing is not held within these time frames, the order will be dissolved.

e) The adult must receive at least 48 hours notice of the hearing, unless for good cause shown, a shorter time is allowed by the court. He/she has a right to be present at the hearing and represented by counsel. If the adult is indigent, or the chancellor or judge determines he/she lacks capacity to waive the right to counsel, then the court will appoint counsel.

6-05-03 Types of Emergency Orders

Emergency orders may give the department the authority to consent to medical examinations, treatment and/or placement of an adult to:

1) prevent imminent danger,

2) for protection from abuse or neglect to prevent imminent danger, or

3) to prevent sexual abuse.

The specific authority granted will be based on the needs of the adult and on the level of danger. "Immediate" threat of danger allows for the most intrusive legal action while "mild" imminence of danger allows for the least intrusive court intervention.

6-05-04 Custody Orders

"Custody" as used in the Adult Protection Act is the right of the Department or other person or entity responsible for the adult's welfare, to order the transport to and/or the retention of the adult in such a location, e.g., hospital or nursing home, and to consent to the provision of any protective services ordered by the court to prevent imminent danger to the adult.

The Department continues to be responsible for the adult's physical custody until relieved by the court and this authority over the adult's physical care

continues even if the immediate imminence of danger is relieved. However, it is at this point that other persons should be sought to act as conservator if the appointment of such a person will enable the adult to receive the level of care and/or protection needed. When it appears that the custody order is no longer needed in order to prevent the adult's death or the adult regains his/her capacity to consent to services then DHS will request a review by the court of the necessity of continued custody by the department. The court will require documentation that the adult's condition has changed and that custody by the department is no longer needed.

"Custody" does not authorize the department to handle the adult's estate, if any; or to pay the adult's expenses. The disbursement of the adult's resources may be accomplished by the adult's temporary guardian under T.C.A. 71-6-107(6) or by a conservator (T.C.A. 34-11-101, 34-12-101 and 34-13-101 et. seq.).

6-05-05 **Temporary Guardian** T.C.A. 71-6-107(a)(6)

Adults who have sufficient resources to pay for court ordered care/treatment must pay such expenses, or for those without resources arrangements must be made for indigent care/treatment. Whenever DHS seeks a custody order for an adult who is unable to obtain the care/treatment he/she requires until someone is given access to his/her resources, the petition to the court should include a request that a temporary guardian be appointed. The appointment of the temporary guardian under this provision of the act [71-6-07(a)(6)] should be requested in the same petition in which custody of the adult is sought or the appointment may be requested in an amended petition or a motion filed by the Department for such purpose. **DHS staff cannot serve as the temporary guardian for the APS client.**

- The temporary guardian will secure and disburse the adult's resources in order to pay for the medical or nursing care facility or alternative living arrangement.

- The temporary guardian may serve for no longer than 6 months from the entry of the order authorizing provision of protective services. However, the court in its discretion may extend such period for a period no longer than an additional six (6) months.

- The guardian shall file with the court an accounting of the resources used.

If the adult will need someone to manage his/her affairs or have other responsibilities not addressed by the "temporary guardian" provision, then the requirements for appointment of a conservator will be followed.

6-05-06 **Court Ordered Placement**

A custody order may allow specific authority to consent to the adult being hospitalized or placed in a nursing home. When available other alternative living arrangements may be authorized, such as, residential homes or Family Homes for Adults.

Prior to filing a complaint with the court for an order authorizing removal of an adult from his or her chosen place of residence, the department shall make reasonable efforts to exhaust all practical alternatives to the removal of the adult from the chosen residence. T.C.A. 71-6-107(a)(1)(A)

Exception: The TN Adult Protection Act cannot be used to order placement of adults into developmental centers operated by the Dept. of Mental Health and Developmental Disabilities. T.C.A. 71-6-108

6-05-07 **Post Placement Examinations** T.C.A. 71-6-107(a)(b)

Adults taken into legal custody and placed in a non-medical placement must have an examination in order to determine the cause of the condition which has resulted in the adult's lack of capacity to consent. This examination(s) is always required unless such determination was made at the time of the final hearing. The purpose of this examination is to ensure that the cause of the incapacity is known and that appropriate care and/or treatment is obtained.

The required examination(s) should be obtained within two weeks of placement. In some cases an accurate diagnosis may be completed with one examination while in others a full range of examinations and tests may be needed. These may include a neurological, a psychiatric evaluation, CAT scan, MRI, etc. Once the cause of the incapacity is determined, prescribed treatment should be arranged.

6-05-08 **Payment of Examinations**

In the event the adult has sufficient resources, insurance, TennCare or Medicare to cover the cost of the required examinations, these should be used as the first option. When there are no other options available, the Department may be billed the Medicaid rate for the examinations. Prior to arranging an examination read Section 11 Appendix 11-02 for instructions on arranging and paying for examinations.

6-06 CAPACITY TO CONSENT T.C.A. 71-6-102(11)

When it has been determined that the client is in need of protection and the client will not or cannot consent to services, in spite of intensive efforts on the part of the counselor and others whose help could be enlisted, consideration must be given to:

a. **Whether or not** the client's decision making capabilities are impaired, and
b. the **degree** to which decision making capabilities are impaired.

"Capacity to Consent" as defined in the law, means:

> **"the mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts: <u>A decision itself to refuse services cannot be the sole evidence for finding the person lacks capacity to consent</u>."**
> T.C.A. 71-6-102(11)

This definition was originally developed by the Court of Appeals in its opinion in **DHS** vs. **Northern** (Tennessee Court of Appeals, 1978). The court distinguished between capacity and sanity with the following analogy:

> "Capacity is not necessarily synonymous with sanity. A blind person may be perfectly capable of observing the shape of small articles by handling them, but not capable of observing the shape of a cloud in the sky.
>
> "A person may have 'capacity' as to some matters and may lack 'capacity' as to others."

It is possible for a person to be generally of sound mind and lucid but in one area of their lives their comprehension may be "blocked, blinded or dimmed to the extent" that they are "incapable of recognizing facts which would be obvious to a person of normal perception."

Adults have a right to make their decisions and do not have to make decisions which necessarily seem reasonable to others. **The adult does have to show that he/she:**

1) comprehends the facts of his/her condition,
2) comprehends the impact of the decision, and
3) understands and accepts the results of the decisions which are made.

Example: A person who recognizes that they will die if they do not have surgery, but still chooses not to have the surgery, will be allowed to make such a choice.

In order to assist in determining whether or not an adult has the capacity to make decisions for himself/herself the following three questions must be addressed:

1. Does he/she know what his/her condition is?

2. Does he/she know the consequences of refusing the needed care/treatment and/or services?

3. Does he/she accept the consequences of his/her decision?

If it is clear that the adult has the capacity to make his/her own decisions then court action is not possible.

The counselor will assess the situation on his or her observations and observations of persons in a position to know of the client's appearance, behavior, symptoms, orientation to reality, lack of rational thinking and other such information. The counselor will also seek opinions from other professionals - psychiatrists, physicians, psychologists, public health nurses, social workers, etc. The object of the observation and investigation is to make a sound judgment as to whether or not the client is able to make the decision.

6-07 IMMINENT DANGER T.C.A. 71-6-102(9)

"Imminent danger" is defined in the law as:

> **conditions calculated to and capable of producing, within a relatively short period of time, a reasonably strong probability of resultant irreparable physical or mental harm and/or the cessation of life if such conditions are not removed or alleviated.**

The above definition was expanded from the original definition of “imminent danger of death” given by the Court of Appeals, in **Department of Human Services** vs. **Northern** (Tennessee Court of Appeals, 1978.) The Court recognized the vagueness of the phrase “imminent danger of death” but added that it is no more vague than the subject matter, as courts, legislative assemblies and physicians have struggled to define "death".

The opinion of the Court of Appeals handed down on the Northern case included the following comments:

> "Danger is a word of many degrees. It may imply strong or weak probability or mere possibility, according to the context of circumstances."
>
> "Imminent means close in point of time, but closeness is likewise a term of many degrees, according to the circumstances."
>
> **"For an authorization to mildly encroach upon the freedom of the individual, a relatively mild imminence or danger of death may suffice. On the other hand, the authorization of a drastic encroachment upon personal freedom and bodily integrity would require a correspondingly severe imminence of death."**

In practice, when considering the degree of imminence required for a specific action to be justified, the degree of encroachment upon personal liberty must also be weighed. For example, requesting a court order to consent to a temporary protective placement during dangerously cold weather would require less of a threat than an order to consent to amputation. Amputation is considered one of the most extreme examples, as it is an action which is permanent and irreversible. Amputation would require a strong imminent danger. Court orders will be considered for a wide range of situations. The decision regarding the type of legal intervention required by the case and the corresponding degree of imminent danger will be made through supervisory and legal consultation.

6-08 REVIEW OF COURT ORDERS BY DHS

Court orders giving the department custody of, or other decision-making authority over, an adult must be reviewed at least every 6 months and a decision made regarding the need for DHS to continue to have such authority. This review will be completed by the counselor and the FSI, with consultation from DHS legal counsel as needed. Staff working with an adult should be constantly aware of changes in the adult's condition which may warrant restoration of the adult's rights to make his/her own decisions. At least once every 6 months the record must include documentation of the need for the court order to remain in force. This documentation should address:

a) the adult's capacity to consent <u>and</u>

b) the risk to the adult if the order is changed and his/her rights restored.

If the court order can no longer be justified then supervisory and legal consultation should be obtained.

6-09 REVIEW OF COURT ORDERS BY THE COURT T.C.A. 71-6-116

A motion for the court to review the order may be filed at any time by either party to the proceeding or any interested person on behalf of the adult.

DHS will file for a review by the court at any time when the prerequisites for the order no longer exist.

6-10 EMERGENCY PETITIONS FILED BY A PRIVATE NON-PROFIT AGENCY T.C.A. 71-6-107(a)(7)

The law provides that private non-profit agencies representing disabled adults may petition the court under the emergency provisions in the law. The stated criteria for court intervention under the emergency provisions must be met. Additionally, the basis for the private non-profit agency to petition will include the refusal of TDHS "to exercise the powers granted to it" by the emergency section of the law.

When such an agency decides to petition the court TDHS must first be notified of their intent to file the petition. When the department is notified of this intent the supervisor of Adult Protective Services and the DHS attorney must be immediately advised of the stated intent.

If the court finds that an order authorizing protective services is warranted, then TDHS' responsibilities will be specified by the court, which may include custody of the adult. The Department's responsibilities will be the same as if the Department had been the petitioner.

If the court finds that an order authorizing protective services is not warranted, then the petitioning agency will be responsible for the cost of the court-appointed attorney for the adult and the court costs.

6-11 NON-EMERGENCY COURT ORDERS

6-11-01 Necessary Conditions

The law provides for non-emergency court intervention on behalf of an adult who does not consent, or who withdraws his/her consent to services; when the Department determines that the adult:

a) is in need of protective services; and

b) lacks the capacity to consent to services.

The conditions for non-emergency intervention may exist when the investigation is begun or they may develop in a case which is long term. Supervisory consultation should be obtained whenever such conditions are believed to exist.

The counselor and supervisor review the adult's capacity to consent and fully discuss the advantages and disadvantages of court intervention. Before court ordered services are requested we must determine that such services will reduce or eliminate the risks to the adult.

6-11-02 **Capacity to Consent**

Refer to "Capacity to Consent" under Section 6-06.

6-11-03 **Procedures**

When the Department makes the decision to seek court intervention the **DHS attorney** shall draft the petition to file with the court. This petition will be based on the Legal Referral completed by the counselor. After the petition is filed, the following action is taken:

a) A hearing is scheduled; no order is entered until the hearing.

b) The adult must have ten (10) days notice of the hearing.

c) The adult has a right to be present and represented by counsel. If the adult is indigent, court costs and the cost of representation will be borne by the state.

6-11-04 **Types of Non-Emergency Orders**

The court upon finding that the adult **is in need of protective services and lacks capacity to consent** to such services may enter an order authorizing the provision of protective services.

Orders obtained under this section may give the department **authority to consent to protective services including medical care and in-home services**. The department cannot be granted custody of an adult, under this provision, therefore, involuntary placements or hospitalizations cannot be made.

While APS may be authorized to consent to medical care in a non-emergency proceeding, it will be only in those cases in which the adult lacks the capacity to consent but is actually not refusing medical care. For example, an adult who consented to the hospitalization but is now incapable of consenting

(coma, etc.) and needs tests or surgery. If the adult **refuses** medical care then we need a **custody order** from the court before DHS can impose treatment upon the adult. See Custody Orders in "Emergency Court Intervention Section, 6-05."

In order to obtain an order to consent to in-home services which impact on the adult's care or environment we do not have to show imminent danger of irreparable harm and the non-emergency proceeding can be used.

6-11-05 Review of Court Orders

Refer to "Review of Court Orders by DHS," Section 6-08, and "Review of Court Orders by the Court," Section 6-09.

6-12 SEARCH WARRANT

The law includes a provision for obtaining a search warrant when there is probable cause to believe an adult is being abused, neglected or exploited and we are unable to gain entry or access to the adult in order to proceed with the investigation. The inability to complete the investigation may be due to the adult's or another person's refusal or inability to allow entry or access. The DHS attorney is to be contacted when there is a case in which a search warrant from the court is needed. See Enter Private Premises to Investigate in **Section 3**. T.C.A. 71-6-103(f)

6-13 INJUNCTIVE RELIEF T.C.A. 71-6-104

Temporary restraining orders (TROs) and permanent injunctions can be used in APS cases when needed to ensure the protection of the adult client. The following include two general types of situations when this intervention may be used:

Uses as provided in T.C.A. 71-6-104(a)

- May be used at any point in a case.
- May be used to prevent the caretaker from interfering with the provision of protective services.
- May be used to require the caretaker to disclose the whereabouts of the adult.
- For other potential uses consult DHS attorney.

Uses as provided in T. C. A. 71-6-104(b)

- May be used to protect the adult client or other vulnerable adults from a **perpetrator who is indicated** in an APS case and in which the identity of the perpetrator cannot be released without the provision of appropriate due process procedures. See **Section 4-14** “Release of Identity of Perpetrators to Employers or Licensing Agencies.”

Use when a **perpetrator is indicated** and needs to be prohibited from further contact with vulnerable adults.

The court may enjoin from providing care for any person, on a temporary or permanent basis, any employee or volunteer, who the court finds has engaged in the abuse, neglect or exploitation of an adult. This applies to situations in which the employee or volunteer is involved in the case of an adult. The abuse, neglect or exploitation may have occurred in a number of settings, including institutions, group homes or foster homes and regardless of whether or not the person, facility or other arrangement for serving adults is licensed to provide care for adults.

In cases in which we are unable to release to the alleged perpetrator's employer or other entity with whom the perpetrator is associated information identifying the perpetrator without providing appropriate due process procedures, and we are concerned about the continued safety or care of the adult client or other vulnerable adults, then the TRO or permanent injunction is an option available to us in providing protective services. Consultation with the supervisor and DHS attorney is required.

6-14 PROHIBITIONS TO USE OF THE ADULT PROTECTION ACT

T.C.A. 71-6-108

The law prohibits the use of legal intervention under the Adult Protection Act under the following conditions:

Living Wills - Legal Intervention to provide medical care for the adult who has executed an unrevoked living will, will not be sought when the provision of medical care would conflict with the terms of the living will. T.C.A. 71-6-102

Treatment by Spiritual Means - The adult who relies on or is receiving treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment shall not be considered to be abused or neglected. T.C.A. 71-6-102

Mental Health Commitments - The APS law cannot be used to adjudicate an adult as incompetent or to commit an adult to a mental health institution. T.C.A. 71-6-108

Involuntary MR Placement – The APS law cannot be used for involuntary placement in a developmental center operated by the Department of Mental Health and Developmental Disabilities; even if involuntary protective services are needed to prevent imminent danger of irreparable physical or mental harm or death. T.C.A. 71-6-107 (a)(5)(A)

6-15 PAYMENT FOR SERVICES

The Department cannot pay the cost of the client's care (room, board, treatment). This is true even though the Department is obligated to cooperate with the Court. When the Court has ordered treatment and/or a protective placement for a client then we will secure available resources to meet the needs of the client.

If the client's income and resources are adequate then it is expected that the Court ordered care should be paid from the client's resources. If the client does not have adequate resources then we will help to initiate appropriate applications, such as SSI, TennCare, etc. Full use will be made of local resources which are available to clients at reduced rates or free of charge. While eligibility is being determined it may be necessary for the counselor to seek temporary help from local resources which agree to help in emergency situations, such as churches and civic groups.

Exceptions: Mental and/or physical examinations requested by DHS and ordered by the court as discussed in this Section may be paid by the Department.

6-16 MENTAL HEALTH COMMITMENTS

6-16-01 Emergency Involuntary Hospitalization (Mental Health)

T.C.A. 33-6-103

When a person due to his mental illness poses an IMMEDIATE substantial likelihood of serious harm (see definition of substantial likelihood of serious harm under Judicial Commitment) if he is not immediately detained, he may be taken into custody without a civil order or warrant by an officer who is authorized to make arrests, or by a licensed physician, or by a licensed psychologist who has a health service provider designation. The custody is for the purpose of immediate examination for certification of need for care and treatment.

For examination of an individual who is thought to meet emergency hospitalization standards, contact the mental health crisis team serving the area. A list is attached (Appendix **Section 11-12**) but in Shelby County, Midtown Mental Health Center operates the crisis services for the entire county; in Davidson County, contact the Mental Health Cooperative; in Knox County, contact Overlook Center. In all other counties, contact the mental health center which customarily serves the area. Crisis teams can provide certification for emergency hospitalization but may provide appropriate alternatives such as respite care or coordination of other appropriate mental health services.

Local law enforcement, if involved, should be instructed to use the crisis team for evaluation. If a crisis team exists in an area, the law enforcement agency is not authorized to transport to a regional mental health institute for involuntary hospitalization without the involvement of a crisis team. Additionally, a regional mental health institute is not authorized to admit on an emergency basis without the involvement of the crisis team.

If the examining mental health professional determines that:

(1) a person is mentally ill,
AND
(2) the person poses an IMMEDIATE substantial likelihood of serious harm because of the mental illness,
AND
(3) the person needs care, training, or treatment because of the mental illness,
AND
(4) all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person, then the professional completes a certificate of need for emergency involuntary hospitalization and the sheriff can transport to the hospital or treatment resource. At the hospital or treatment resource,

a physician examines a second time under the standards above; if the physician agrees, a second certificate of need is completed and the individual is admitted for emergency diagnosis, evaluation and treatment.

Upon admission, the General Session's judge where the hospital or treatment resource is located must be notified immediately. The judge makes the decision to either order the immediate release of the individual or order the individual held for diagnosis, evaluation and treatment for not more than five days, excluding weekends and holidays. A hearing must be held before the end of the five day period with a court determination of whether the person meets the requirements for judicial commitment AND that if involuntary treatment is not continued the defendant's condition resulting from mental illness is likely to deteriorate rapidly to the point that the defendant would again be admissible under emergency standards.

At the hearing, the court determines if probable cause exists to detain the individual for further evaluation and treatment not to exceed 15 days. Should treatment beyond the 15 days be required, the individual must be judicially committed.

Department's Role:

The role of DHS staff is to bring the adult to the attention of the mental health crisis team or a law enforcement officer. If a person in such a situation has family or close friends, they can be advised of the client's need for assistance. If they are able and willing to take responsibility for obtaining mental health involvement or services, then our services may not be required. See **Section 5-17** Use of Mental Health Crisis Teams.

6-16-02 **Judicial Commitment (Mental Health)** T.C.A. 33-6-104

1. **Petition**

A petition to judicially commit an individual may be filed by the parent, guardian, spouse, or a responsible adult relative of the person alleged to be in need of care and treatment, a licensed physician, a licensed psychologist who has a health service provider designation, a health or public welfare officer, an officer authorized to make arrests in Tennessee, or the head of any institution in which the person is located.

Courts having jurisdiction may differ according to the size of the county. It is most frequently the Circuit Court but may also be Chancery Court, Juvenile Court or Probate Court. The staff in each county office will have to determine the appropriate court in the county.

The petition must be filed in the county where the individual is located. This may be the county of residence or if the individual has been hospitalized under T.C.A. 33-6-103, it will be the county where he is hospitalized.

The petition shall be accompanied by a certificate of either two licensed physicians or one licensed physician and one licensed psychologist who has a health services provider designation. The examining professional must have examined the individual within three days from the date on the certificate. The certificate which they complete must provide a factual basis for support of the involuntary hospitalization standards.

The standards for indefinite involuntary hospitalization or judicial commitment are:

the person is mentally ill,
AND
the person poses a substantial likelihood of serious harm
because of mental illness,
AND

the person needs care, training, or treatment because of the mental illness,
AND
all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person.

NOTE: The substantial likelihood of serious harm in this section is not IMMEDIATE as is necessary under the emergency hospitalization requirements (Section 6-14-01).

SUBSTANTIAL LIKELIHOOD OF SERIOUS HARM IS DEFINED IN T.C.A. 33-6-104(a):

a person has threatened or attempted suicide or to inflict serious bodily harm on himself, **OR**

the person has threatened or attempted homicide or other violent behavior, **OR**

the person has placed others in reasonable fear of violent behavior and serious physical harm to them, **OR**

the person is unable to avoid severe impairment or injury from specific risks, **AND**

there is a substantial likelihood that such harm will occur unless the person is placed under involuntary treatment.

If the individual refuses to submit to an examination, the petition shall be accompanied by a sworn statement by the petitioner that the individual has refused to be examined by a certifying professional and that the petitioner has good reason to believe that the individual is mentally ill, and the reasons for that belief. When the court reviews this petition, known as the "unwilling subject," the court may order law enforcement to detain and transport the individual to be evaluated.

2. **After Petition is Filed**

Upon filing the petition, the court shall give notice to the individual of the time and place of the hearing. Notice shall also be given to the individual's parent, guardian, spouse or adult next of kin, and the head of any institution in which the individual may be. The hearing shall be set for a time as soon after the filing of the petition as the business of the court will allow, but not more than twenty (20) days from the date the petition was filed.

The individual can retain or the court may appoint counsel to represent the individual in these proceedings. At the request of counsel, the court shall grant a continuance for up to seven (7) days for preparation of the case.

3. **The Hearing**

During the hearing, the individual on whom the petition is filed, the petitioner and all other persons required to receive notice shall have the opportunity to appear at the hearing and to testify. Both the petitioner and the individual, as represented by counsel, may cross-examine witnesses. The court, in its discretion may receive the testimony of any other person. The court shall determine the place of the hearing.

The testimony of a certifying professional may be made by deposition or affidavit with the consent of the individual or his counsel. At least one of the certifying professionals shall be a witness at the hearing, or a professional who would be qualified as a certifying professional under the commitment statute may testify instead if the person has examined the individual within ten (10) days of the hearing.

4. **The Order**

Upon completion of the hearing the court may find by clear, unequivocal and convincing evidence that the individual meets the judicial commitment standards and may therefore commit the individual to a hospital or treatment resource. If the court finds otherwise, it shall terminate the proceedings, dismiss the petition and release the individual unless he is being held under the provisions of some other law.

If commitment is to a state hospital, the individual may be admitted when the hospital has suitable available accommodations. Some private facilities, when payment arrangements have been made, take judicial commitments.

5. **Department's Role**

The first responsibility of APS is to bring the adult who appears to need a judicial hospitalization to the attention of one of the parents, a guardian, spouse, a responsible adult relative or a licensed physician and to encourage them to seek appropriate help for the adult. Should one of the above named people be able to follow through with obtaining the hospitalization needed by the adult, then APS will no longer need to provide services to that adult.

In other cases one of the above named individuals may be willing to seek the help needed by the adult client but may be unable to get that help without services from the Department. In such cases, APS may assist by providing referrals, transportation or other services which enable the client's need to be met.

Secondly, there will be situations where APS is unable to get anyone to help such an adult and APS is unable to get the adult to agree to leave his home or see a doctor. In situations where the department believes the adult needs to be hospitalized and APS is the only agency in a position to see that the client receives the needed evaluation and treatment, then it is appropriate for APS to initiate legal action.

A decision would have to be made as to the best plan of legal action. Under Mental Health Law, the Department may file a petition for judicial hospitalization. Under the Adult Protection Act, the Department may file a petition asking for custody of an adult in order to have the adult examined by a physician. **The Adult Protection Act cannot be used to commit a person to a mental institution.**

If the adult's situation is such that APS is sure the adult needs to be hospitalized for mental health services, then it is appropriate for the department to file a petition under the Mental Health Law. A referral to the DHS attorney should be completed according to the outline for a judicial commitment.

6-16-03 Legal Action

1. Decision to Take Legal Action

The decision to refer the situation to the DHS attorney for the initiation of legal action is to be made jointly by the social counselor and supervisor. This decision should be made as a last resort after all considerations have been taken into account. There must be a full understanding of the client's

condition and the availability of resources to meet the client's needs. Be sure all relative and friend resources have been explored.

2. Referral to DHS Attorney for Legal Intervention by the Department for Protection of an Adult

All petitions must be prepared by the attorney. There are form petitions for involuntary commitment, both emergency and judicial, available from the Department of Mental Health/Developmental Disabilities, crisis

teams and regional mental health institute attorneys. All other referrals recommending legal action will be made using the form HS-2752 **Legal Referral for Actions Pursuant to the Tennessee Adult Protection Act.** This form is found in Section 9 Forms and is available on the DHS Intranet site. The legal referral is used to request:

a. Custody for purposes of placement of the adult in a facility;
b. Permission to consent to medical treatment;
c. Permission to consent to in-home protective services;
d. Mental or physical examination to determine lack of capacity to consent and/or imminent danger;
e. A search warrant to obtain access to the adult;
f. Injunctive relief ordering a caretaker or other person to stop abuse, neglect or exploitation, to stop interfering with the provision of protective services, or requiring protective action.
g. Other legal intervention

General instructions for preparing Form HS-2752 are found in **Section 9**. Specific instructions for each section are on the form. It is essential to fill out the form completely with thorough and accurate information. Obtain any missing information if at all possible. Lack of adequate and/or accurate information will jeopardize having a successful outcome in court or even the attorney's ability to take the case to court.

3. **Referral to DHS Attorney for Judicial Commitment of an Adult**

There are form petitions for involuntary commitment, both emergency and judicial, available from the Department of Mental Health and Mental Retardation, crisis teams and regional mental health institute attorneys. Referrals recommending legal action to obtain judicial hospitalization of adults should be prepared in duplicate and routed to the Program Supervisor for approval. After approval, the original should be transmitted to the DHS Attorney for initiation of appropriate legal action. If consultation with the Adult Protective Services staff in the State Office is requested, one copy should be transmitted to the Program Director.

The referral should include the following information in the order listed:

1. name, address and age of the adult in need of hospitalization;

2. whether or not the adult has ever been committed to a mental health facility by the Court. Has he/she been released from the hospital? The records of the Chancery, Circuit, Juvenile (in some counties) and County Clerk's Office in the county where he/she was committed will have this information;
3. name and address of conservator if such has been appointed;

4. name and address of the two certifying professionals (2 physicians or one physician and one psychologist) who examined the adult and certified the adult's need for hospitalization. Include the date of the examination.

   If the adult has refused to be examined by a physician then the petitioner must give reasons for believing the adult is mentally ill, poses a "likelihood of serious harm" and be able to state that all other less drastic alternatives to commitment to a mental hospital or treatment resource are unsuitable. Petitioner must make statements referenced under the “unwilling subject” provisions (6-16-02 1.).

5. Include specific indications of the adults "substantial likelihood of serious harm" as defined in the section on judicial commitment;

6. Name and addresses of the individual's parents, conservator, spouse or adult next of kin;

7. Name and address of witnesses, their willingness to testify and the relevant facts each can attest to from his own personal knowledge;

8. Include preliminary indications of the ability of the adult to secure legal representation;

9. Date of referral, name and title of the counselor and supervisor.

6-17 CONSERVATORSHIP T.C.A. 34-11-101; 34-12-101 and 34-13-101 et. seq.

The "Limited Guardianship Proceedings for Disabled Persons Law" was passed in 1979. In 1993 a new **Guardianship and Conservatorship Law** was enacted and went into effect January, 1993.

WHEN

When APS becomes involved with an adult who appears to be unable to manage himself, his property, or both, the Department may provide legal services to establish Conservatorships. This will be done for APS clients only and when:

1) such service will enhance the ability to protect the adult and prevent imminent danger to the adult and
2) such a legal service is a more effective means of meeting the adult’s needs for protective services than use of the Adult Protection Act.

Some examples of situations which meet the above criteria include:

- a conservatorship is a means of making a transition from custody of the adult by the Department under the Adult Protection Act to the long-term care and supervision by a suitable relative or other suitable person;

- the adult who is in the Department's custody under the Adult Protection Act has resources in significant amounts and the temporary guardian is unable or unsuitable to provide services under the Act which are required by the particular circumstances of the adult;

- the temporary guardian's term of service for an adult in the Department's custody is about to expire under the terms of the Act, etc.

A decision for the Department to act as the petitioner for a conservator will be made on a case by case basis.

The Department **will not** provide legal services or establish a conservator for an adult:

- who does not otherwise meet adult protective services criteria or who is not already in the Department's custody and who only needs a conservator to manage finances or property;

- simply as a legal service to the adult or his/her family members who may not be able to afford, or do not want to expend, funds necessary for the legal services to establish a conservatorship;

- who for any other reasons does not want to undertake the legal process necessary for appointment of a conservator

- because members of the community feel that the Department should undertake the establishment of a conservatorship for the adult;

APS staff should in no instance attempt to give legal advice to persons who contact us.

LEGAL REFERRAL

To file for a Conservatorship for an adult protective services client the Department must:

1) be able to demonstrate a need for protective services,
2) have medical evidence to show the adult is unable to manage him/herself and/or his/her property, and
3) have a person willing and able to be appointed who we can recommend to be appointed to serve as conservator.

The legal referral for Conservatorship should include the following information:

1. The name, birth date, address and current location of the adult if different from the address.

2. State the specific authority requested from the court and request the appointment of a temporary guardian.

3. Specific examples of the conditions and circumstances of the abuse, neglect, or exploitation which make it necessary to seek legal action.

4. Specific indications of the adult's "lack of capacity to consent."

5. The name and address of the proposed conservator. The Tennessee District Public Conservator may be appointed for adults age 60 and over.

6. Relationship of the proposed conservator to the client, if any.

7. A statement of the proposed conservator stating a willingness to serve.

8. Reasons we are recommending this person as appropriate and able to serve.

9. Name and address of the client's "closest relative" so that notice can be given to that person by certified mail.

10. Name and address of the person with whom the client is living and/or name and address of the person who has custody of the client if such a situation exists.

11. Name and address of the client's physician or psychologist.

12. A copy of a sworn medical examination or a statement that the client has been examined but no report has been received or a statement that the client has refused to be examined voluntarily, with a request that the court direct the client to undergo a medical examination.

13. A statement specifying what rights are to be removed from the client.

14. A list of all financial information and property or statement that the information is unknown and why.

15. State whether or not the adult has ever been committed to a mental hospital; if so, what hospital.

16. State the full names, addresses and telephone numbers of witnesses and the particular facts each will be able to testify to from his/her own personal knowledge.

17. State the name and address of any payee for Social Security (SS), Supplemental Security Income (SSI) or other benefits which may exist. State any existing powers of attorney.

18. State the specific service plan for the adult and how the proposed plan will enable the adult to be protected.

19. Preliminary indications of the financial ability of the adult to secure legal representation and to provide all other necessary expenses of representation in the court proceedings; also include the adult's ability to pay for the services requested.

20. Date of referral, name and title of counselor and supervisor.

OTHER OPTIONS

For anyone (a relative or other interested party) who calls the Department on behalf of a client suggesting/requesting that the Department file for a Conservatorship, the following alternatives are suggested:

- the adult should whenever possible retain the services of an attorney
- if legal assistance is available in the county they may be referred to a legal services office
- a person who is unable to retain an attorney and is unable to receive free legal services may wish to go to the Judge and explain the situation and request the court's assistance in referring the person to an attorney
- for those 60 years of age and above, refer to the Area Office on Aging Public Guardianship Program

6-18 DOMESTIC ABUSE

The Spousal Abuse/Domestic Violence Act (T.C.A. 36-3-601) went into effect July, 1984. There have been several amendments to the Act which have expanded the options available under the Act and in 1995 changed the title to "Domestic Abuse." Because of these expansions more adults known to adult protective services may now benefit from the provisions of the Act.

A copy of the Act is in Appendix, Section 11-07.

6-18-01 Who May Benefit from Orders of Protection

The adult age eighteen (18) and above or the emancipated person under age eighteen (18) who has suffered or is threatened with abuse by a present or former adult household member may benefit from an order of protection.

Abuse, as defined in the Act, refers to the infliction or attempt to inflict physical injury on an adult other than by accidental means; physical restraint; or malicious damage to the personal property of the abused party. T.C.A. 36-3-601

The definition of abuse in the Act is broader in scope than the definition of abuse in the Adult Protection Act. Abuse in the Domestic Abuse Act is defined to include the malicious damage to the property of the adult, as well as non-accidental injury to the adult. The Act differs also since it is not based on the adult's vulnerability.

A family or household member as defined in the Act refers to spouses, persons living as spouses, persons related by blood or marriage, and **other persons jointly residing in the same dwelling unit**, who are eighteen (18) years of age or older. T.C.A. 36-3-601

The definition of family or household member is broad in scope and includes the majority of persons with whom an abused adult may reside.

6-18-02 What Is An Order of Protection

An order of protection is an order granted for a fixed period of time, not to exceed one (1) year, to protect an adult from abuse. This order is granted by a court with jurisdiction over domestic relations matters. The order may include, but is not limited to:

- directing the abusing adult to refrain from abusing or threatening to abuse the adult client.

- granting to the adult client possession of the residence or household by evicting the abusing adult, by restoring possessions to the adult client, or both.

- directing the abusing adult to provide suitable alternate housing for the adult client when the abusing adult is the sole owner or lessee of the residence or household.

- awarding financial support to the adult when the abusing adult and the adult client are legally married.

- prohibiting the abuser from stalking the adult.

- prohibiting the abuser from telephoning, contacting, or otherwise communicating with the adult.

When a protection order is in effect, a law enforcement officer is empowered to arrest the abusing adult without a warrant under specific conditions T.C.A 36-3-611. The provision for prompt arrests without a warrant provides added protection for the client who is in great fear and danger.

6-18-03 How to Obtain an Order of Protection

Petitions for domestic orders of protection may be filed with the local court which handles domestic relations matters. The necessary forms to seek a protection order are available from the clerk of the court upon request. The clerk of the court will give any necessary assistance to the adult client, who is not represented by an attorney, in completing or filing the forms to petition the court.

The adult is not restricted to the use of the forms provided by the court. Any legally sufficient petition may be acceptable.

The Act allows the adult who wishes to file a petition for a protection order to do so even when their income is so limited that they cannot afford an attorney, the filing fee, or litigation tax. Since many of the adults referred to the Department have limited income or in some instances no income, this provision should eliminate a barrier for those adults who would be financially unable to file a petition if an attorney, filing fee, or litigation tax were required. Also, since the court provides the form and assistance in completing and/or filing the form, this should be beneficial to the adult who would become lost in the process without assistance.

6-18-04 Department's Role in Domestic Abuse Situations

The primary role of APS is to share information with the abused adult regarding the available options under the Domestic Abuse Act, when it is believed that a protection order will enable the adult to be protected. The abused adult should be referred to the local court with jurisdiction over domestic relations matters or when available to a domestic violence agency.

Each county office will have access to a Domestic Relations Court, but each county office may not have access to a domestic violence agency.

Domestic violence orders of protection may not be appropriate in all family violence situations, nor will they be accepted by all clients who may benefit from them. In some situations when the abused adult has been given information about their options they will be able to go to the court and petition for an order of protection; whereas, in other situations it may be necessary to assist the adult in this process. However, APS staff will not render legal advice or complete the forms for an Order of Protection for the adult except when authorized by the court. Refer to **Section 6-18-05**

The role of APS staff is to make abused adults aware of their options and to provide assistance as is necessary in their gaining access to the court.

6-18-05 Making the Decision to Use the Adult Protection Act and/or the Domestic Abuse Act

Some adult protective services clients may benefit by a referral to the court to file a petition under the Domestic Abuse Act. Examples of case situations in which adult clients may benefit from the Act include the following:

- cases in which an adult family member or household member who resides in the client's home has abused and/or threatened the client with abuse;
- cases in which a client is abused and/or threatened with abuse while residing in the home of an adult family member or household member; and
- cases in which an abused adult will need financial support from the person who has abused and/or threatened him/her with abuse, and who has the duty to provide support to the abused adult.

While the aforementioned case situations may be viewed as fairly routine, we should also give consideration to more unusual case situations in which we may use the Domestic Abuse Act in adult protective services case situations:

In some rare instances it may be appropriate to use the Domestic Abuse Act in conjunction with the Adult Protection Act, (non-emergency provision T.C.A. 71-6-107(b)) such as in a case situation in which the Department has alleged and provided sufficient proof to the Court that an adult lacks the capacity to consent to protective services, and the Court has authorized the Department to provide protective services on behalf of the adult. The Department may then consider petitioning the Court as "next friend" using the Domestic Abuse Act (T.C.A. 36-3-601

through 613) to request an order of protection for the adult who has been abused by a family or household member.

This case situation is described to assist in increasing the manner in which APS gives consideration to the use of the Domestic Abuse Act with adult protective services clients who have been abused by a family or household member. It is expected that the Domestic Abuse Act will seldom be used in this manner.

The Adult Protection Act (T.C.A. 71-6-104) gives the Department the legal options to seek restraining orders and injunctions which can be enforced by contempt proceedings, just as in the Domestic Abuse Act. The legal options available under the Adult Protection Act should be used when they will provide the adult client with all the protection needed. If the adult cannot be fully and adequately protected then APS may consider using the two laws. There are some protections and provisions under the Domestic Abuse Act which are not available under the Adult Protection Act: such as those listed in Section 6-18-02 and T.C.A. 36-3-606. The protection required by some adults may be more readily available under the Domestic Abuse Act.

When there is a question regarding the decision to refer the adult client to the court with jurisdiction over domestic relations; to use the legal interventions of the Adult Protection Act; or to use both the Adult Protection Act and the Domestic Abuse Act this decision should be made jointly by the counselor and the supervisor in consultation with the DHS attorney for the district.

6-19 REFERRALS FOR LEGAL INTERVENTION

Referrals requesting legal action to obtain Court authority to provide Protective Services (Form 2752) should be prepared in duplicate and routed to the Field Supervisor I for review and approval. After approval, the original should be transmitted to the DHS Attorney in the District Office for initiation of appropriate legal action. If consultation with the State Office, Adult Protective Services staff is requested, a copy of the referral should be sent to the Program Director in the State Office.

6-20 CIVIL REMEDY – T.C.A. 71-6-120

In addition to other remedies provided by law, an abuse, neglected or financially exploited elder person or disabled adult has the right under certain circumstances to recover compensatory damages and costs – including court costs – in a civil action against the perpetrator(s). Punitive damages may also be awarded if the conditions specified in number 3 below are met. This was added to the Adult Protection Act in 1999, and includes the following key points:

1. Through civil action, an elderly or disabled person can file an action to recover compensatory damages for abuse, neglect, sexual abuse or exploitation if shown by clear and convincing evidence that the allege perpetrator committed abuse or exploitation. This action can be filed by the victim, their conservator or personal representative. This right is not extinguished by the death of the victim. Damages awarded by the court can include costs, including attorneys' fees and court costs, in addition to compensatory damages.

2. The recovery of money or property of the elderly or disabled adult, if shown by clear and convincing evidence that the alleged perpetrator obtained it by fraud, deceit, coercion or other means. This action can be filed by the victim, their conservator or personal representative. This right is not extinguished by the death of the victim.

3. The recovery of punitive damages if the abuse was committed by a licensed health care practitioner, or if the abuse was committed by the staff of a facility licensed or required to be licensed under the health or mental health licensing laws.

4. The Department of Human Services is not required to initiate any legal action to seek recovery of damages on behalf of the adult victim.

APS staff can share with APS clients, family members, or legal representatives the information about this additional legal option now available to victims. It is also appropriate to provide a referral to legal services providers or other attorneys for victims who may wish to pursue this option.

GUIDE TO LEGAL INTERVENTIONS

The majority of adults who are determined to need protective services accept services voluntarily. When an adult is determined to be in need of protective services, but does not consent to services or withdraws his consent there are legal options under the Adult Protection Act that must be considered, prior to closing the case. In these situations, the supervisor should be consulted, and the decision made jointly by the counselor and supervisor whether or not legal action should be sought. Access to the court is only available via the DHS attorneys. Legal options are explored only after all other measures have been used to provide needed services, without court intervention.

Several legal options are available through the **ADULT PROTECTION ACT** as described in #s 1-5a. These include:

- Search Warrant
- Order for Mental/Physical Examinations
- Order to Consent to Medical Exams, Treatment and/or Placement... Temporary Guardian
- Order to Consent to Protective Services Including Medical Care and In-Home Services
- Injunction

In addition to the legal options under the Adult Protection Act, Adult Protective Services clients may benefit from other statutes as described in #s 6-8a:

- Orders of Protection under Domestic Violence Act
- Conservatorship Act
- Mental Health Commitments - Emergency Custody and Hospitalization - Judicial Commitment/Non Emergency Provision

The following is a description of each of the above stated legal options, when each is used and what is needed/required to use each one:

LEGAL OPTIONS UNDER ADULT PROTECTION ACT	WHEN IT IS USED	WHAT IS NEEDED
1. **Search Warrant** T.C.A. 71-6-103(f)	Most frequently used to complete an investigation when unable to gain access to the adult.	- Report of abuse, neglect or exploitation (A/N/E) of an impaired adult - Probable cause of A/N/E.
2. **Mental or Physical Examinations, Only** T.C.A. 71-6-103(l) rev. 10/28/04	Most often used during investigation to assist in determining whether or not an adult is in imminent danger and/or lacks the capacity to consent to services.	- Probable cause to show adult lacks capacity and is being abused, neglected or exploited. Hearing required before order issued unless can show imminent danger; that delay for a hearing could decrease adults chances of survival.
3. **Temporary Restraining Orders and Injunctions** T.C.A. 71-6-104	May be used at any point in a case. Most often used to prevent caretaker from interfering with provision of protective services. May be used to require caretaker to disclose whereabouts of adult. To stop access of perpetrators to victims.	- Need for protective services - Evidence or knowledge which shows caretaker is interfering - May be used in other situations consult DHS attorney - Preponderance of evidence that person is the perpetrator
4. **Order to Grant Authority to DHS to Consent to Services T.C.A. 71-6-107(b)(1)**	May be used in a long term case situation to obtain authority to consent to services on behalf of an adult in a non-emergency situation. Primarily receive authorization to provide in-home services. Medical care is authorized only if the adult is not refusing or resisting treatment.	- Need for protective services - Lacks the capacity to consent

LEGAL OPTIONS UNDER ADULT PROTECTION ACT	WHEN USED	WHAT IS NEEDED
5. **Orders to Grant Authority to DHS to Consent to Medical Examinations, Treatment and/or Placement** T.C.A. 71-6-107(a)(1)	May be used at any point in a case in an emergency situation if the adult is in need of immediate medical treatment, surgery, hospitalization, nursing home care, protective residential/foster care placement, etc. and a custody order is required to provide the needed protection and services.	- Need for protective services - Lacks the capacity to consent - In imminent danger or in cases of sexual abuse -The requested court order does not conflict with a living will
5a. **Temporary Guardianship under Adult Protection Act - Emergency Order** T.C.A. 71-6-107(a)(6)	May be used only when DHS is given an emergency court order to consent to care, treatment or placement in a medical facility or alternative living arrangement. (See #5 above). The temporary guardian may serve no longer than **six months** (a 6 months extension is possible).	- Court order granted (under #5 above) to DHS - Adult has resources to pay for care/treatment - Unable to obtain care/treatment without the appointment of a temporary guardian who will use resources to defray costs of care.

LEGAL OPTIONS UNDER OTHER STATUTES	WHEN USED	WHAT IS NEEDED
6. **Conservatorship** T.C.A. 34-11-101 et. seq. ***Public Guardianship for the Elderly** T.C.A. 34-7-101	May be used when APS client is unable to manage himself and or property and the appointment of a conservator offers best possible protection on a long term basis.	- Need for protective services - Medical evidence to show adult is unable to manage himself and/or property - A person willing to be appointed as conservator. *A TN District Public Guardian may be appointed for adults age 60 and above.
7. **Orders of Protection under the Domestic Violence Act*** T.C.A. 36-3-601 *not restricted to spouses	May be used at any point in a case when an adult is abused or threatened with abuse by a present or former household member. DHS will only serve as petitioner in those cases in which the adult is unable to act in his/her own behalf and DHS has been given authority to act in his/her behalf under a court order (as specified in #4 above). In other instances the APS client may be referred to the court for assistance under the Domestic Abuse Act.	- Petition to the Court for an Order of Protection based on the abuse or threat of abuse of an adult by a present or former household member - Petition may be filed by the adult who cannot afford an attorney
8. **Mental Health Commitments: Emergency Custody and Hospitalization** T.C.A. 33-6-103	May be used at any point in a case in which an APS client who appears mentally ill and is showing immediate substantial likelihood of serious harm to self or others; or is unable to avoid severe impairment or injury from specific risks.	- When there is no one available or in a position to do so; contact a physician, licensed clinical psychologist or law enforcement officer to take the adult into immediate custody for an examination.
8a. **Judicial Commitment/Non-Emergency Provision** T.C.A. 33-6-104-, 33-3-601	Same as above, except less immediate risk. When an APS client appears to be in need of in-patient evaluation/ treatment and DHS is the only agency in a position to obtain the treatment then DHS may petition the court.	- Petition to the court shows that the adult is (1) mentally ill (2) poses a “likelihood of serious harm,” to self or others; the adult is unable to avoid severe impairment or injury - Two physicians must certify the adult’s need for hospitalization. These may be obtained by court order based on above-stated evidence

SECTION 7 – INSTITUTION/FACILITY INVESTIGATIONS

Investigations Involving Nursing Homes, Other Facilities/Institutions Licensed by the Department of Health, Mental Health/Developmental Disabilities Institutions/Facilities, and Unlicensed Health Care Facilities, etc.

This section includes information regarding investigations of abuse, neglect and/or exploitation in nursing homes and other institutions/facilities. See **Section 5** for nursing home information on the topics listed below:

- Relocation
- Nursing Home Waiting List
- Third Party Signatures
- Emergency Telephone Approval of PAEs
- Overbedding
- Patient Care Advocate
- Long-Term Care Ombudsman

7-01 FACILITY INVESTIGATIONS

Residents of institutions/facilities who are believed to be abused, neglected and/or exploited are to be reported to DHS the same as adults who live in private residences. The Department will follow the investigative procedure as is described in **Section 3**, except for facilities where we have an **agreement with special provisions** as described in the remainder of Section 7.

Exception: The Department of Human Services shall <u>not</u> be required to investigate, and the Department of Mental Health/Developmental Disabilities shall <u>not</u> be required to report to DHS, any allegations of abuse, neglect or exploitation involving its residents that occur <u>within any facility operated by DMH/DD</u>. Allegations occurring in such institutions shall be investigated by investigators of DMH/DD. However, allegations of any incidents which involve residents of such facilities but occur outside the premises of the facilities, that occur in community residences licensed by DMH/DD or in facilities licensed by other authority <u>shall</u> be reported to and investigated by DHS/APS. T.C.A 71-6-103(k)(2).

In most of those cases in which APS conducts investigations in facilities or requires access to persons or information in facilities, APS will be dealing with the administrator of the facility. The administration assumes the role of the *caretaker*.

Therefore, the cooperation or lack of cooperation will be responded to as described in **Section 3-11 Caretakers**.

Licensing Authority

When investigating within a facility, the counselor needs to see the license(s) under which the facility is operating.

- Facilities may have multiple licenses, depending on whom they serve.
- The facility may be unlicensed; if so, this should also be documented.

The type of license held by the facility or the lack of a license determines how the investigation will proceed, and influences coordinating investigative activities with other agencies. See the remainder of Section 7 for joint investigations and sharing of information.

For policy regarding Release of Identity of Perpetrators, see **Section 4-14**.

7-02 ENTRY INTO HEALTH CARE FACILITIES/SERVICES AND PRIVATE PREMISES

Legal Authority

T.C.A. 71-6-103(e)and 71-6-103(k)(2)
Any representative of the Department may enter any health facility or health service licensed by the State of Tennessee at any reasonable time to carry out the responsibilities of the Department as they pertain to Adult Protective Services, **except** that the Department has **no** authority to enter an institution operated directly by the Department of Mental Health/Developmental Disabilities to investigate allegations of abuse, neglect or exploitation **occurring in the facility**. DHS/APS does have the authority to enter those facilities operated directly by DMHDD as part of an investigation of abuse, neglect or exploitation of a resident of the facility but which occurred while the resident was outside of the facility.

T.C.A. 71-6-103 (f)
Any representative of the department may, with consent of the adult or caretaker, enter any private premises where any adult alleged to be abused, neglected or exploited is found, in order to investigate the need for protective services for the purpose of carrying out the provisions of the law.

If the adult or caretaker does **not** consent to the investigation, a **search warrant** may be issued upon showing of probable cause that an adult is being abused, neglected or exploited, to enable a representative of the department to proceed with the investigation.

7-03 INSTITUTIONS OPERATED BY THE TN DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES: MEMORANDUM OF UNDERSTANDING

Memphis Mental Health Institute
Western Mental Health Institute
Middle Tennessee Mental Health Institute
Lakeshore Mental Health Institute
Moccasin Bend Mental Health Institute
Arlington Developmental Center
Clover Bottom Developmental Center
Greene Valley Developmental Center

(Investigations in **community placements**, facilities, etc., **are not** addressed in this section, 7-03.)

See Memorandum of Understanding – TN Department of Human Services and TN Department of Mental Health and Developmental Disabilities, **Section 11-14**.

The Tennessee Department of Mental Health/Developmental Disabilities **operates** as well as licenses the institutions listed above. In almost all instances, the residents of MH/DD facilities are assumed to be unable to protect themselves due to their disabilities. The administration, in the role of caretaker, is therefore expected to assume responsibility for protecting the residents. The administration of each institution/facility is responsible for providing supervision and protection for the residents. DMH/DD regulations require that each institution develop written policy prohibiting mistreatment, neglect or abuse of residents, and establish a procedure for reporting and investigation.

Allegations that residents of these facilities are believed to be abused, neglected and/or exploited while outside the facility must be reported to DHS. The Department of Mental Health/Developmental Disabilities and the Department of Human Services have a Memorandum of Understanding regarding investigations. The Department of Mental Health/Developmental Disabilities will be responsible for investigating abuse, neglect or exploitation alleged to have occurred within the facilities which it directly operates, and is not required to report these allegations to DHS.

7-03-01 TDMH/DD Reporting Procedure

It is expected that each institution will have a reporting procedure for its staff to follow. TDMH/DD has designated their facility superintendents as the persons responsible for reporting to TDHS/APS.

1. Upon receipt of a report alleging abuse, neglect, mistreatment or exploitation occurring outside of the facility, it is the responsibility of the superintendent of the TDMH/DD facility to immediately notify the appropriate TDHS/APS intake office of the allegations. If APS staff are not available, a message will be left on the APS voice mail system giving:
   - the calling party's name,
   - his or her telephone number,
   - where the caller can be reached and
   - the nature of the call.

2. APS will accept referrals from any person within the institution. Staff at various levels may want to report directly to APS as they may be afraid to go through the system developed within the institution. All staff come under the mandatory reporting provisions of the APS law, except that staff in facilities operated by the state are not required to report to DHS allegations of abuse, neglect or exploitation occurring within the facility. (Facility staff will follow the procedure developed by DMH/DD for reporting allegations which will be investigated by DMH/DD investigators.)

   When reports are made to DHS intake staff, the reporter will be "encouraged" to report the incident to the administration of the institution when the report is made by someone other than the superintendent and the complaint does not include allegations involving the administrator or investigator. The name of the person making the referral to DHS **must** remain confidential and may be revealed **only** when a court with jurisdiction under the law orders the release of the reporter's identity.

7-03-02 Sharing Referrals Between TDHS/APS and TDMH/DD

Each report to APS of abuse, neglect or exploitation of adults who are residents of DMH/DD facilities will be reported to the superintendent of the appropriate DMH/DD facility according to the procedures developed by the institution.

Exception: Referrals which include allegations involving the superintendent or the TDMH/DD investigator as a part of the complaint will not be reported to the superintendent, but will

be reported directly to the Assistant Commissioner of Mental Health or Developmental Disabilities Services.

7-03-03 Appropriate and Inappropriate Referrals

Appropriate referrals to APS are those which allege abuse, neglect or exploitation of specific residents which occur outside the institution directly **operated** by DMH/DD, and which meet the definitions in the Adult Protection Act of the following terms: **Adult, Abuse, Sexual Abuse, Neglect,** and **Exploitation.** See **Section 1-05.**

Inappropriate referrals to APS are those

- alleging abuse, neglect or exploitation occurring within a facility directly operated by DMH/DD,
- alleging general complaints regarding the operation of or the care provided within a facility, i.e., unsanitary conditions, dirty linen or cold food, etc. which do not pose an immediate risk to the client. Such conditions may be violations of facility standards but may not be of such a nature or degree as to warrant a referral for an APS investigation. Referrals alleging violations of facility standards can be reported to the Complaint Coordinators at the following Division of Mental Retardation Services Regional Offices:

  - East TN: 1-888-310-4613
  - Middle TN: 1-800-654-4839
  - West TN: 1-800-308-2586

7-03-04 TDMH/DD and TDHS/APS Response to Reports

1. TDMH/DD Response To TDHS/APS Reports

   DMH/DD will respond in accordance with its investigation policy. In general, this response is as follows:

   a. Emergency Referrals

      When the referral includes allegations of: 1) physical abuse; 2) sexual abuse; 3) serious or unexplained injury; 4) any injury requiring treatment by a physician; or 5) death, the investigation by DMH/DD will be initiated within one hour upon receipt of the referral.

   b. Non-Emergency Referrals

      When the referral involves a non-emergency allegation, the investigation by TDMH/DD will be initiated by the next working day.

2. TDHS/APS Response To Reports

As stated above, APS will accept appropriate reports of abuse, neglect and/or exploitation from any person. However, DMH/DD has identified the DMH/DD facility superintendent as responsible for reporting for each TDMH/DD facility.

a. Emergency Referrals

When referrals allege:
1.) serious illness
2.) abuse which is occurring (outside the facility) at the time of the referral
3.) sexual or physical abuse occurring (outside the facility), with the alleged perpetrator having access to the victim
4.) an incident (outside the facility) of sexual abuse which has occurred within the past seventy-two (72) hours
5.) visible injuries or possible life-threatening conditions (incurred outside the facility)

the APS investigation will be initiated on the same day the referral is received and accepted by APS. (See **Section 2-08**).

b. Non-Emergency Referrals

When the referral involves a non-emergency allegation, the investigation by APS will be initiated within no more than **five (5)** working days from the date the referral was accepted by APS.

This response time for non-emergency referrals is from an agreement between TDHS/APS and TDMH/DD (Memorandum of Understanding, July, 1997, page 5, C-2).

7-03-05 Investigations In DMH/DD Institutions

1. Reports of Abuse, Neglect or Exploitation **In** Facilities **Operated** by TDMH/DD (See Section 7-03 above.)

Allegations of abuse, neglect or exploitation which occur in those facilities operated directly by DMH/DD as listed in Section 7-03 will be investigated solely by DMH/DD investigators. DMH/DD will be responsible for taking appropriate action to ensure the safety of residents while in facilities which it operates.

2. Reports of Abuse, Neglect or Exploitation To a Resident of a Facility **Operated** by TDMH/DD Occurring While **Outside** the Facility

Allegations of abuse, neglect or exploitation of a facility resident occurring while the resident is outside the facility will be investigated by APS the same as allegations regarding adults in private residences. In the course of the investigation, APS staff will have the authority to enter a DMH/DD facility to have access to the adult and to any other persons or records in the facility which are needed to conduct the investigation.

DMH/DD investigators and APS staff are encouraged to conduct investigations jointly if it is appropriate. In most cases, however, separate investigations are warranted. This will be determined on a case-by-case basis. Under current law, joint investigations will be the exception to routine types of investigations.

When conducting joint investigations, each agency will share information with the other relevant to the investigation process, including requested copies of that information. Excluded are preliminary materials created by the DMH/DD investigator and/or the APS counselor, i.e., informal, preliminary notes; written draft reports or assessments that have not been finalized, etc.

1. Initiating The Investigation

   a. Upon receipt of the referral, appropriate reports will be made to law enforcement, licensure and/or TBI using Form 1215. See **Sections 2-11, 2-12 and 2-13**.

   b. APS staff will contact the facility superintendent or his/her designee regarding the need for APS staff to see and interview the client. Exceptions to contacting the superintendent may be made at the discretion of the APS investigating staff.

      If the superintendent of the facility is included in the allegations, see Section 7-03-02 above.

2. Investigative Steps

   a. **Interview the APS client**. The APS client must **always** be seen and interviewed by APS staff. Some clients will not be able to communicate with the counselor, but all reasonable efforts will be made to observe and communicate with the client.

Special note is to be made of the client's physical condition, mental functioning, behaviors and status, including any injuries or indicators of neglect or maltreatment. See **Sections 3-07, 3-08, and 3-09**.

If needed in order to complete the investigation, the superintendent will be contacted and assistance requested in obtaining an evaluation or examination of the client.

b. Request all information available to the facility which pertains to the client's condition or the alleged incident(s).

c. Request a **medical report** on the client's condition.

d. **Observe the location** of the alleged incident. Note the physical setting and compare it with the account of how the incident occurred for feasibility.

e. **Interview collateral contacts**. Any person believed to have information which will assist in determining the client's condition, risk and need for services will be interviewed. This may include physicians, nurses, social workers, family members, other patients, facility staff, etc.

- Request that the institution give the APS counselor staffing schedules, and the names and addresses of all staff members who had any responsibility for the resident, the opportunity for contact with the resident or who may have any knowledge relevant to the allegations.

- Compare statements of staff and other persons to establish the facts of the case, to determine what may have happened to the resident and the validity of the allegations which were made.

- **Never interview a staff member in the presence of a third party such as a union representative, friend, spouse, etc.** Staff of the institution are bound by confidentiality, and APS will not be a party to their revealing confidential information to a person who is not authorized to have access to such information. However, the person's attorney may be present during the interview.

f. **Records to be reviewed** may include medical and mental

health records, staffing schedules, personnel records, incident and investigative reports, etc. Law enforcement and fiscal records may also be relevant to the investigation. See 3. ACCESS TO RECORDS –TDHS/APS below.

g. Check the State Abuse Registry to determine whether the alleged perpetrator has been previously indicated as a perpetrator. See **Section 3-17** for the procedure to check the registry.

h. Interview the alleged perpetrator regarding his/her account and explanation of the allegations. Carefully compare the statement with other statements and evidence. See **Section 4-13-02** for considerations related to perpetrator interviews to avoid giving undue weight to a denial or other explanation. If it is not possible to interview the perpetrator, the case file must document the reason it was not possible.

3. Access To Records – TDHS/APS

Any APS representative who is involved in the conduct of an investigation shall be allowed access to the mental and physical health records of the client which are in the possession of the DMH/DD staff or facility. In addition, APS will have access to any other relevant records necessary to complete the investigation, including but not limited to personnel, personnel history, staffing patterns, work schedules, etc.

Exception: Drug and alcohol treatment records may not be released except by a court order or by a release signed by the patient. Therefore, these records **will not** be shared with APS **unless** a court order or release is provided to DMH/DD.

7-03-06 Confidentiality

A. If APS obtains any information from DMH/DD in the course of its investigation, the confidentiality of which is protected by statute, APS may not make use of or disclose such information except as may be necessary to carry out the provisions of the Tennessee Adult Protection Act, or as may be authorized by the statute establishing confidentiality.
(T.C.A. 71-6-103(j)(5))

B. APS is prohibited from releasing the identity of the **person who reports** abuse, neglect or exploitation to **anyone**. Therefore, this information will **not** be shared with TDH/DD.

7-03-07 Investigative Reports

A. TDMH/DD Responsibility

The final investigative report of DMHDD of those incidents reported to APS will include but is not limited to:

- what happened to the client and the client's resulting condition;
- individuals interviewed;
- any medical reports and/or photographs related to the client;
- actions taken by the facility to protect the client.

The definitions for abuse, neglect, mistreatment and exploitation used in the report will be the definitions provided by the TDMH/DD statute and rules.

The final report will be forwarded to APS within thirty (30) days of its receipt by the DMH/DD investigations coordinator. This report is considered final even when a grievance is subsequently filed. DMH/DD will provide APS further notice of any personnel action overturned as a result of the grievance.

B. TDHS/APS Responsibility

APS will send correspondence to the DMH/DD superintendent of the facility stating the determination by APS of the status of the client's need for protection, with a copy to the DMH/DD investigator at the facility in question. This letter will be sent within thirty (30) days from the completion of the APS investigation. The correspondence will include the APS case assessment Form 2638.

See **Section 4-14** Release of Identity of Perpetrators to Employers or Licensing Agencies

7-03-08 Action(s) to Protect the Client

1. TDMH/DD Responsibility

Upon receiving a complaint of abuse, neglect or exploitation within a facility which DMH/DD operates, the DMH/DD investigator will ensure that the client is protected. If the investigator is unable to protect the client, then assistance will be requested from the facility superintendent. If the facility is unable to protect the client, then the investigator will request assistance from the TDMH/DD Commissioner.

TDMH/DD has standing under T.C.A. 71-06-103(k)(1) to petition the court for protection of the client. See **Section 7-03-11**.

2. TDHS/APS Responsibility

A. **Reports –** See **Section 7-03-07**

B. **Actions to Protect the Client**

If APS determines that an adult who is a resident of a facility operated by TDMH/DD has been mistreated and is in need of protective services:

1. APS will advise the institution of our concerns, including the perpetrator's access to the client or other vulnerable adults. The institution is responsible for taking steps necessary to protect the adult in their care and control.

2. If the facility is unable or unwilling to take the necessary action to protect the client, then APS staff will request assistance from the APS Program Supervisor.

3. In the event of an impasse between Program Supervisors and the DMH/DD institution, the state office should be advised of the case situation.

4. If the institution continues to be unable or unwilling to take steps necessary to protect the client, then APS will:
   - make a report of the investigation, and
   - make recommendations to the Commissioner of the Department of MH/DD for needed services.

   It is then the responsibility of the DMH/DD Commissioner, to take the necessary steps to protect the resident from abuse, neglect or exploitation as stated in T.C.A. 71-6-103(k)(1).

   In these situations, APS staff will continue to be involved and report regularly on the lack of action by DMH/DD. These reports will be:
   - made at least **quarterly**.
   - routed through the APS Program Supervisor to State Office for approval by the DHS Commissioner, prior to being submitted to the Commissioner of DMHDD.

5. All interventions available to the APS program through services or legal action will be used as appropriate in cases in which abuse/neglect occurred while the resident was in the care and control of an individual who is not a staff member of the facility and the incident occurred off-site.

C. **Client Is Protected By Injunction**

1. APS staff may intervene with action to protect a client from an indicated perpetrator. Protective activities may include filing a motion with a court of jurisdiction for temporary or permanent injunctive relief to restrain the perpetrator from a caregiving role to the client or other vulnerable adults. Such action must have supervisory approval and be taken in consultation with the DHS attorney. See **Section 6-13** for policy related to Injunctive Relief.

2. In cases where an injunction is granted, APS staff will ensure that the name of the indicated perpetrator is submitted for inclusion on the State Abuse Registry maintained by the Department of Health. See **Section 3-17** for policy related to the State Abuse Registry.

7-03-09 Conclusion of Investigation and Case Closure

A. APS will notify the person who made the referral of our decision.
B. APS will send correspondence as described above in **7-03-07**.
C. When joint investigations are completed, either department, upon receiving the final report of the other, will administratively close its investigation twenty-one (21) days after receipt of that report. If the receiving department desires to continue the investigation, it may notify the other department that the investigation will continue.

7-03-10 Limited Investigations

When APS initiates an investigation **after** DMH/DD:

- has completed its investigation,
- has determined the abuse/neglect occurred off-site by non staff **and**
- has been able to take appropriate action to protect the client,

then APS *may* choose to do a **limited investigation** which will include:

- a review of the DMH/DD **investigative** file and report;
- an interview with the client;
- when feasible, an interview with the alleged perpetrator.

If APS believes the action(s) taken by DMH/DD has provided protection for the client, then further involvement by APS may not be necessary. If there are any remaining issues or concerns, APS will continue the investigation to resolve any of these issues or concerns.

If an injunction against the perpetrator is appropriate, APS will petition for an injunction. See **Section 6-13** for policy on filing injunctions.

7-04 THE TN DEPARTMENT OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES' STANDING TO PETITION THE COURT USING THE ADULT PROTECTION ACT T.C.A. 71-6-103(K)(1)

The law provides that DMH/DD has the authority to petition the court under the Adult Protection Act when the following conditions exist:

- The referral of abuse, neglect or exploitation of an adult who is a resident of a facility owned and operated by DMH/DD has been investigated by APS, and the necessary protection of the adult has not been provided.

- A report of the APS investigation has been submitted, along with any recommendations for needed services to enable the adult to be protected, to the Commissioner of DMH/DD; and

- A petition to the court is needed to enable DMH/DD to meet its responsibility for providing the necessary protection of the adult.

7-05 INVESTIGATIONS IN LICENSED AND UNLICENSED HEALTH CARE FACILITIES

The **Tennessee Department of Health** has the legal responsibility to license facilities which provide varying levels of health care services. These include Hospitals, Nursing Homes, Assisted Living Facilities and Homes for the Aged.

- **Homes for the Aged** provide room, board and supervision or assistance with activities of daily living to ambulatory adults.
- **Assisted-Care Living Facilities** (ACLF) provide, in addition, assistance with typically self-administered medical needs.
- **Nursing Homes**, with full-time professional, licensed staff have the capacity to provide a higher level of residential care, including 24-hour assistance with essential daily activities and attention to medical needs.
- **Hospitals** provide nursing, medical and/or surgical care for the diagnosis and/or treatment of deformity, injury and/or disease.

The Department of Health, through its Health Care Facilities Division, has the duty to also ensure that these facilities comply with the state's minimum standards for safety and quality of services, and that the needs of residents are appropriate for the level of care being provided. Due to the nature of their responsibilities for such facilities, Health Care Facilities surveyors will be in contact with adults who are vulnerable and may be in need of protective services.

The Department of Human Services Adult Protective Services and the Department of Health, Division of Health Care Facilities have entered into agreements (Memoranda of Understanding, September, 2000, **Section 11-03**) for conducting investigations of abuse/neglect/exploitation that are alleged to occur in any licensed or unlicensed health care facility, and for providing protection to adults who are receiving services from these facilities.

Further, the Tennessee Department of Health maintains **Health Related Boards** which are responsible for licensing professional staff who are required by Tennessee state law to be licensed. The licensing board of each profession has the authority to discipline licensed members of the profession. Actions may include, but are not limited to, requiring additional training, suspending or revoking licenses. See Appendix **Sections 11-04** and **11-05.**

The Tennessee Adult Protection Act (T.C.A. 71-6-101 et. seq.) mandates the **Department of Human Services** to provide protection to residents of licensed and unlicensed health care facilities just as it mandates protection for adults in other living arrangements. The law requires that Adult Protective Services staff receive and investigate reports of abuse, neglect, or exploitation of adults. The investigation and provision of services to adults include:

- notifying law enforcement and licensing authorities upon receipt of the referral;
- making a timely response,
- interviewing the adult client,
- performing investigative tasks necessary for determining the risks to the adult,
- assessing and providing appropriate intervention,
- notifying appropriate agencies and boards of the investigative findings,
- maintaining confidential records, and
- notifying the referent after the investigation/assessment process has been completed.

The **Department of Health, Division of Health Care Facilities'** scope of services includes the following:

- license health care facilities annually;
- communicate licensing requirements to and facilitate the application process for unlicensed facilities
- conduct surveys for licensure and certification, and ensure that state minimum standards are met and federal conditions of participation are complied with;
- investigate complaints pertaining to licensed health care facilities;
- investigate complaints pertaining to unlicensed health care facilities as the law permits; and
- provide consultation to providers regarding the above.

Upon receipt of any complaint that alleges abuse, neglect and/or exploitation of an adult client or patient, the Division of Health Care facilities will immediately make a report to APS. In addition, any time that a Health Care Facilities employee observes, suspects or is made aware of the possibility of abuse, neglect or exploitation of an adult, a report will be made to APS intake. When abuse, neglect or misappropriation of funds is not identified in an initial complaint but is confirmed during the course of an HCF investigation, the HCF staff will report this information to their Central Intake. The HCF Central Office staff will then add the new information into complaint details as an addendum and report to APS.

7-05-01 Appropriate and Inappropriate Referrals

Appropriate referrals for APS investigation are those that allege abuse, neglect or exploitation of specific adults in licensed or unlicensed health care facilities.

Inappropriate referrals for APS investigation are those alleging general complaints regarding the operation of, or the care provided within the facility, such as dirty linen, cold food or unsanitary/unsafe conditions, which may be in violation of licensing standards, but are not of such a nature or degree as to warrant an APS investigation.

APS will refer the caller to the TDH Health Care Facilities Centralized Complaint Intake Unit at 1-877-287-0010 (M-F, 7:00 a.m.—7:00 p.m.) for complaints about licensed and unlicensed health care facilities which are not appropriate for APS investigation or referrals alleging violations of facility standards.

7-05-02 Sharing Referrals Between TDHS/APS and TDH/HCF

TDH/Health Care Facilities

- Health Care Facilities will **immediately** report to APS any abuse, neglect or exploitation of an adult.

- Health Care Facilities will incorporate into a licensed facility's deficiency report whenever APS notifies HCF that a facility did not make a **timely** report to APS in accordance with state law.

- If the referral is not accepted for investigation by APS, the Department of Health, Health Care Facilities will complete their investigative procedures.

DHS/APS

- APS will accept for investigation those referrals which allege abuse, neglect or exploitation of specific adults in licensed and unlicensed health care facilities. See Intake, **Section 2-02**.

- APS will share with TDH/HCF all referrals reported to APS of abuse, neglect or exploitation of adults in licensed or unlicensed facilities **excluding the name of the referral source**.

- APS will determine whether the referral is accepted for investigation, and **will identify to HCF the APS supervisor who will oversee the APS investigation**. The following notifications will be made to HCF by telephone **and** on Form 1215 (HS-0875) or other written report as indicated. See **Section 2-13** for policy regarding Notifications to the Licensing Authority.

  - APS will notify HCF **immediately** of referrals which allege physical or sexual abuse or life threatening neglect of a resident in a licensed or unlicensed health care facility.

  - Referrals received after hours will be reported on the **next working day** to the appropriate regional office.

  - Notification to HCF of all other (non-emergency) referrals will be within **two (2) working days** from the date the referral is received.

  - APS will notify HCF of any event in which a **licensed facility** does not report allegations of abuse, neglect and/or exploitation of an adult in its care **in a timely manner as required by state law**. Notification may be by telephone, but will be followed by a brief written notification to the appropriate HCF regional office that includes:
    a. the name of the facility;
    b. the name of the alleged adult victim;
    c. the date on which the incident became known to the facility;

d. the date on which the report was made to APS;
e. a brief statement of the type of alleged maltreatment.

- APS will refer to the TDH/HCF Centralized Complaint Intake Unit at 1-877-287-0010 (M-F, 7:00 a.m.—7:00 p.m.) complaints alleging conditions which do not warrant an APS investigation. (See Section 7-05-01 above.) This includes any conditions the APS counselor may encounter in the facility at any point in the investigation that raises concerns about the conditions or general quality of care being provided in the facility.

- Any facility complaint referred to TDH-HCF by APS or TBI does not require a subsequent referral/notification back to HCF by the recipient agency (i.e. APS 1215).

7-05-03 Initiating the Investigation

Upon receipt of the referral, APS will notify TDH, law enforcement and the TBI-Medicaid Fraud Unit, when appropriate, of abuse, neglect or exploitation allegations using Form 1215. The notification to any of these entities with form 1215 is in addition to any previous telephone contact. See **Sections 2-11, 2-12** and **2-13**.

APS staff are encouraged to coordinate investigations with TDH/HCF when possible, including scheduling of interviews, etc. However, the APS investigation will be initiated within response time frames required by APS policy. See **Section 3-04** Initiation of Investigation.

7-05-04 Special Considerations For Investigations In Unlicensed Facilities

The investigative process is essentially the same for APS in both licensed and unlicensed health care facilities except for the following consideration:

- **HCF** staff have no authority to enter the premises of an unlicensed facility, as it is essentially private property. Therefore, APS staff will recognize that HCF cannot enter an unlicensed facility, either with APS staff or independently; the HCF surveyor must have the permission of the provider to enter the premises. Nor will HCF be conducting an investigation in the unlicensed facility. In all other matters of collaboration/sharing information, the relationship between APS and HCF is the same.

- **TBI** will need to advise APS staff of whether or not they have the authority to enter the unlicensed facility in question.

7-05-05 APS Investigations In Health Care Facilities

Joint investigations are strongly encouraged between APS and TDH/HCF as circumstances permit. However, in many instances, TDH may not be able to respond as promptly as APS. APS will respond according to its policy time frames. Even when investigations cannot be conducted jointly, TDH and APS are encouraged to collaborate on investigative activities and assist one another as the law allows.

The APS investigation will include the following steps as dictated by the needs of the specific case:

A. The investigation will generally begin by contacting the facility administrator/operator. This is not a requirement and the decision is left to the discretion of the APS counselor. In some instances, such as when the alleged perpetrator is the administrator, it is best to begin by contacting the client or others who may have knowledge of the allegations. Regardless of the order in which the interviews are conducted, the cooperation of the administrator/operator will be requested during the investigation.

B. **Always** see and interview the APS client, making all reasonable efforts to communicate with and observe the client. Some clients who cannot communicate verbally may be able to convey reliable information with the use of appropriate tools such as figure drawings or dolls. Some clients may have more receptive than expressive language—that is, they may be able to respond to questions and statements with gestures, and or indicate feelings by facial expression and body language. All of these types of non-verbal responses, while not definitive, can serve to indicate to the APS counselor areas of information to pursue further with collateral contacts such as facility staff, family members, etc. In addition, the APS counselor will carefully observe and make special note of the client's physical condition, mental functioning, behaviors and status, including any injuries or indicators of neglect or maltreatment. See Investigations **Sections 3-07, 3-08** and **3-09**.

C. Obtain medical examination/evaluation of the patient's physical condition, date and cause of injuries if existing records/reports do no provide the necessary information. If needed, TDH assistance may be requested to obtain examinations/evaluations.

D. Obtain and review any medical records, incident reports, staffing schedules, personnel records, etc., pertinent to the investigation. Medical records can be used to determine the adult's medical condition, treatment history and whether or not the physician's orders

are being followed by facility staff. Medical records should document when illness or injuries were first noticed, what action was taken, etc.

E. Request TDH/HCF assistance when needed to interpret records, charts, or to determine appropriateness of treatments or interventions which were used or suggested.

F. Interview others who may have information which will assist in determining the client's condition, risk and need for services. These may include but are not limited to physicians, nurses, other staff of the facility, family members, other patients, etc.

G. Check the State Abuse Registry to determine whether the alleged perpetrator has been previously indicated as a perpetrator. See **Section 3-17** for procedures to check the registry.

H. Interview the alleged perpetrator regarding his/her account and explanation of the allegations. Carefully compare this statement with other statements and evidence. See **Section 4-13-02** for considerations in evaluating the alleged perpetrator's statement.

I. Obtain from TDH/HCF a detailed investigative report showing its investigative contacts and conclusions.

J. Complete the investigative assessment on Form HS-2638, APS Investigative Report/Assessment (Facility).

7-05-06 TDH/HCF Responsibilities In The APS Investigation

TDH/HCF may conduct their own investigation according to TDH policy and procedures. However, the agreement between TDH and DHS/APS provides that TDH will assist and support the APS investigation as follows:

A. Encourage coordination between APS and HCF of on-site visits and interviews when possible.

B. Collaborate with APS throughout the investigative process.

C. Provide medical consultation to APS when requested to complete their investigation.

D. Provide assistance to APS when requested, to obtain for review and/or interpret medical records.

Exceptions: When the facility is not licensed, see **Section 7-05-04**.

7-05-07 Action(s) To Protect the Client

In addition to the casework and legal options available to APS in all APS cases, there are additional considerations when attempting to protect residents of health care facilities. Necessary action will be based on the nature of the risk to the adult and the steps which are necessary to eliminate the risk. APS will usually work with the client, interested family and/or the facility staff to correct the situation. In most cases, facility/nursing home administration and or TDH/HCF should be able to take necessary steps to protect the adult.

TDH/HCF will:

A. Ensure that all licensed health care providers take necessary action to protect the health and safety of the patients/residents.

B. Take necessary actions as the law permits to protect the health and safety of the patients/residents in unlicensed health care facilities, i.e. reporting to any professional board, district attorney, TBI and APS.

C. Assist in identifying an acceptable facility in which to admit the adult patient/resident who is in need of such a placement.

D. Assist by providing emergency approval for a waiver when an identified receiving facility's licensed bed capacity would be in excess if the patient/resident in need of such placement were accepted.

E. In those cases in which a resident of a facility needs alternative placement or medical treatment, is in immediate danger or at a high level of risk and is unable or unwilling to accept services from TDH, TDH may ask APS for assistance. APS will determine whether or not legal action is possible.

APS will:

A. Review the actions taken by the facility and advise TDH Health Care Facilities when a licensed facility fails to take necessary action to protect the client.

B. Utilize casework and legal remedies available to APS to protect clients in facilities.

C. When an adult needs to be moved to a different facility for his/her protection, coordinate with TDH to identify an appropriate facility and access the bed.

D. Depending on the type of risks and concerns in an APS case, the Patient Care Advocate and/or Long-Term Care Ombudsman may be requested to assist in resolving identified problems. See Appendix **Section 11-04** and **11-08**.

E. Take appropriate legal action when needed to protect the client who is in immediate danger or at high risk, who is refusing needed placement and/or treatment and has been determined to lack the capacity to make an informed decision. Court action is considered an intrusive intervention, and is to be used only when no less drastic alternative is effective. Other casework options must first be attempted:

- Discuss the situation with the client/family.
- Identify and allay any false fears and/or misinformation.
- If the client still refuses, then determine the client's capacity to consent, seeking TDH assistance with obtaining evaluations, if needed. If the client refuses the evaluation, then contact the DHS attorney regarding a court order for **examination only**.
- If the client is determined to have capacity to consent, then inform TDH of APS' inability to take action.
- If the client is determined to lack the capacity to consent, **and** the client is determined to be in imminent danger of irreparable harm, then make a referral to the DHS attorney.

See **Section 6** for policy regarding Legal Interventions.

Each department will maintain its respective involvement until the risk to the adult has been eliminated and there is no longer a need for services to protect the adult. These actions will be based on the state mandate for each department.

Note: APS will consult with the Department's attorney regarding obtaining an injunction that prohibits an **indicated perpetrator** from providing care to the victim or to other vulnerable adults, regardless of the actions of TDH, unless it is verified that those actions have included obtaining such an injunction. See **Sections 3-17 and 6-13**.

7-05-08 Post Investigative Tasks

1. INVESTIGATIVE REPORTS

APS will share the results of the investigation with TDH/HCF. The investigative report includes all information regarding the investigation and its outcome **except for the name of the referral source**, which remains confidential to APS. Before releasing the post-investigative report, review **Section 4-14** regarding:

- Actions Prior to Release of Information: **Section 4-14-01**;

- Conditions Under Which the Perpetrator's Identity May Be Shared: **Section 4-14-02**;
- Chart For Sharing Information After Abuse/Neglect/Exploitation is Assessed: **Section 4-14-04**.

The APS report to TDH/HCF is always limited to the investigative findings and concerns. It does **not** include any recommendations regarding actions to be taken. It is up to TDH to decide on and take appropriate action.

The agreements with TDH/HCF state that APS reports will remain confidential, will be treated as a confidential part of the TDH files, and under no circumstances will APS reports/files become part of a public record.

APS may share the investigative outcome with relevant law enforcement agencies and licensing boards if those entities request information, as described in **Section 4-14**.

TDH/HCF will provide APS a detailed summary/investigative report of each complaint/referral concerning abuse, neglect or exploitation which it investigated.

When APS and TDH/HCF have differing investigative outcomes, and those differences negatively impact protective intervention by either APS or HCF, the situation will be reported to the Directors or to the Assistant Commissioners of the respective departments, based on the request of the investigating staff. APS Program Supervisors will review the outcomes and send to the APS Director.

2. NOTIFICATIONS

A. APS will notify the referral source of the decision regarding the client's need for protective services at the conclusion of the investigation, observing confidentiality, as in all cases. The notification will be documented on Form 2638.

B. APS will inform appropriate Health Related Boards of investigative conclusions that a licensed individual has been indicated as a perpetrator. Such information will **not** include any recommendation for action. It is the board's responsibility to investigate and to determine whether or not any action will be taken regarding the individual's professional license.

7-06 SUBMITTING AN INDICATED PERPETRATOR'S NAME TO THE ABUSE REGISTRY

Placing the names of individuals who are perpetrators on the State Abuse Registry is a protective action that prevents the indicated perpetrator from providing care to vulnerable adults. The name of the perpetrator will be submitted to the Department of Health for inclusion on the State Abuse Registry when the following conditions have been met:

- The case has been indicated and the perpetrator has been indicated by the investigation; **AND**
- Legal action has been pursued and the court has had a final hearing which resulted in;
  - the individual being named as the perpetrator of abuse, neglect and/or misuse of the adult's funds, <u>and</u>
  - a permanent injunction being granted to prohibit the individual from volunteer or paid caregiving to residents in facilities.

Follow the steps in **Section 3-17** for submitting the required documentation to the Department of Health to have the name of an indicated perpetrator included on the State Abuse Registry.

SECTION 8 - MULTIDISCIPLINARY CASE CONSULTATION TEAMS

8-01 PURPOSE AND FUNCTIONS

The purpose of the Adult Protective Services Multidisciplinary Case Consultation Team is to assist the Department in providing effective services for those adults who have been determined to be in need of protection. The first Case Consultation Team, which was established in 1983, grew out of the need to have guidance and support for staff who were dealing with increasingly complex case situations involving adults referred for Adult Protective Services. It was recognized that in order to adequately protect those adults who suffered from diverse and complex risks, the cooperation of others working in conjunction with the Department would be needed and beneficial.

8-02 BENEFITS FROM TEAM

Benefits which can be gained from the team include:

1) assessing risks to adults;
2) providing input on appropriate methods and approaches the counselor can use in the delivery of services;
3) offering suggestions for possible alternatives and solutions;
4) consultation and support;
5) education of the community on Adult Protective Services issues;
6) casework intervention approaches and strategies;
7) development of case diagnosis and/or prognosis;
8) identification of service gaps/needs;
9) coordination and better utilization of existing resources; and
10) development of resources to meet the identified service gaps/ needs.

The Case Consultation Team is a means of facilitating this process. Additionally, it can prove to be valuable in our difficult role of safeguarding the adult's right to self- determination while insuring his/her right to protection.

The Case Consultation Team is to be used on a case by case basis to provide consultation and support in difficult case situations.

These case situations may include:

- cases in which legal action is being considered and consultation from team is needed;

- case situations in which ideas/suggestions are needed on casework approaches or intervention strategies;

- case situations where there is not a known or immediate resource to meet the client's needs and additional ideas and directions are needed;

- cases in which closure is being considered and the client is in danger, and will not accept services, but appears to have the capacity to make the decision to reject services and thereby remain in danger;

- cases in which the client's ability to make rational choices and decisions fluctuates and his/her decision making ability is at best borderline;

- severe abuse, neglect or exploitation cases where the client remains with or returns to the harmful situation and/or abuser;

- borderline cases in which we have been unable to clearly show that the client is in danger;

- cases in which assistance is needed in making a case diagnosis and/or prognosis;

- cases in which clients have fallen between the cracks (an example might be an adult with a dual diagnosis of mental illness and mental retardation); and

- and those "wits end" cases in which APS staff have been unable to make progress after repeated efforts have been made to provide services.

The multidisciplinary approach is a way to gain greater perspective into the needs of and risks to Adult Protective Services clients and seek more options and alternatives in meeting needs or reducing the risks. Due to the benefits derived from Case Consultation Teams, **a sufficient number of teams are to be established in each district to ensure the availability of a team for staff in each county**. It may not be necessary or feasible to have a team in each county within the district. However, consideration must be given to the distance and amount of time staff would be required to travel to have access to a team. Teams should be available within a reasonable distance from each county.

The team is comprised of key professionals from the local community who have expertise and commitment to working with vulnerable adults. By involving key professionals within the community the department's ability to increase the community's awareness of the protective services program, identify service gaps and needs, and develop or coordinate existing services is enhanced.

The Case Consultation Team is an effective and efficient tool for staff working with Adult Protective Service cases; however, it requires staff with a commitment to the process to make it work.

8-03 DEVELOPMENT AND USE OF APS CASE CONSULTATION TEAMS

8-03-01 Composition of Case Consultation Team

Composition of the teams will vary depending on the resources and needs within the District. Possible team members may include the following:

*Physician (needs alternate/back-up)
*Psychiatrist/Psychologist (needs alternate/back-up)
Nurse
Pharmacist
Gerontologist
Social Worker (Hospital, Mental Health, etc.)
Ombudsman (District level)
Member of Clergy
Representative of Aging Network
Representative of Vocational Rehabilitation
Representative of Development Disability
Nursing Home Administrator
Law Enforcement
Attorney

*indicates the required members.

Team members are sought from those individuals who have expertise or an interest in Adult Protective Services clients and issues. They have a commitment to attend team meetings regularly.

A team member is responsible for carefully considering information presented, making recommendations and advising the department regarding alternatives which may be useful in a case. Team members may also be able to identify needed community resources.

8-03-02 Appointments and Terms of Team Members

A sample **Appointment Letter** is included in **Section 9**.

All team members receive an appointment letter from the District Director. The length of the appointment is one year and begins with the date shown in the appointment letter. Reappointments may occur at the completion of the year's service.

To ensure the smooth operation or functioning of the team it is beneficial to reappoint some of the team members at the end of the year's service. However, to facilitate the orientation process it is desirable to appoint several new members at this time.

Resignations or non-participation of team members must be examined and handled from the standpoint of the teams' ability to function in light of these absences and/or whether or not a required member is involved.

8-03-03 **Liability**

As included in the appointment letter, team members will serve on the team in an advisory capacity with department staff making all official decisions on the cases which are reviewed. In accordance with T.C.A. § 9-8-307(h) they will be registered with the State Board of Claims and will consequently be considered "state employees", for purposes of liability protection. This liability protection will extend within the scope of their duties as a team member except for willful, malicious or criminal acts or omissions or for acts or omissions done for personal gain.

The second page of the **Volunteer Enrollment Form HS-1262**, is completed by each team member and thereafter registered with the Board of Claims. This form is self-explanatory. In the section under **Committees** on the line by **Other**, write in **Adult Protective Services Multidisciplinary Case Consultation Team**. To be registered with the Board of Claims the section of the HS-1262 below the perforated line, **Registration of Volunteers**, should be sent to Volunteer Registration c/o DHS Personnel, Citizens Plaza, 3rd Floor, 400 Deaderick Street, Nashville, TN 37248. A copy of this form should be kept on file, see **Record Keeping** in this section.

8-03-04 **Confidentiality**

A sample **Confidentiality Agreement** is included in **Section 9**.

Each team member signs the agreement to maintain the confidential nature of the information shared with them as members of the Case Consultation Team.

Team members are privileged to confidential, identifying and intimate information. However, **the name of the person making the referral will not be given to the team**. The information discussed during the team meeting is not to be shared with anyone outside the department and the team. This means that any **flow of information from the team to any agency or person is channeled through DHS staff for approval.** This procedure must be followed even if a team member represents the agency designed to receive the information.

8-03-05 Team Meetings

Frequency; Length; Time and Location of Meetings; Who Attends; and Emergency/Special Meetings

The **length of the meetings** will vary depending upon the number and/or complexity of the cases discussed. A recommended length of time is one (1) to two (2) hours.

Time and Location
Team members input should be sought when setting the time (morning or afternoon) and also the possible location (if there is a need to meet outside of the DHS office). As members are recruited there should be discussion of when they are available to meet and suggestions on meeting places (when appropriate). Be flexible when setting a meeting time, for instance, some team members may have a preference to meet at 8:00 a.m. This may be based on the rationale that they have busy schedules and it is easier to set aside an hour or so early in the morning before reporting to their work assignments; whereas, others will feel a need to or be required to check-in at their work places before attending a team meeting. Currently the majority of the teams meet in the DHS offices; however, if holding the meeting elsewhere will enable you to have participation that would not otherwise be available please be flexible. For example, if it is not convenient for the physician to come to the DHS office determine if there is a meeting place at the hospital, if this will facilitate his/her participation.

Who Attends
Only the individuals necessary for team functioning should be present at team meetings: team members, and DHS staff (counselor, supervisor/ coordinator). For in-service training purposes, new DHS staff may attend team meetings as observers. On occasion a team member may ask to bring an individual who may be a future/ potential team member to either replace them or fill another vacancy, the coordinator will decide on the appropriateness of the individuals attendance.

Occasionally professionals involved with the adult who have pertinent information to share, may wish to make a presentation to the team. The coordinator should arrange for and allot time for the professional (who is not a member of the team) to make his/her presentation. The professional should not be present during the general discussion of the case, because of the need to maintain confidentiality. The counselor can share the team's recommendation with the specific professional, as appropriate.

Emergency Meetings
Provisions for calling emergency/special meetings to handle special or emergency circumstances which may develop should be made with the team members.

8-03-06 DHS Coordinator

The DHS Coordinator must have a commitment to the team concept since they are primarily responsible for setting things in motion for the team to operate. The coordinator provides or arranges for orientation of team members. They will also be responsible for setting up the meetings and the agenda. This includes scheduling cases for review and notifying counselors and supervisors of the meeting to enable them to be prepared for presenting their cases. The coordinator will call the meeting, preside, and see that recommendations are recorded and distributed as necessary.

The coordinator serves as a liaison between department staff and team members. The coordinator is responsible for disseminating information to team members and coordinating communication between the team members and department staff.

8-03-07 Record Keeping

The Coordinator for the team should keep a record of the ongoing activities of the team including: copies of appointment letters for each team member, copies of second page of HS-1262 - Volunteer Enrollment form for each team member, copies of forms used by the team, information regarding orientation for team members, and records/minutes for each meeting.

The records/minutes should include: date, time, and place of each meeting; persons present and, if persons present are not team members or DHS staff presenting a case include a statement of their reason for attending; cases reviewed; counselors/ supervisors presenting cases; team recommendations and follow-up or feedback requested. Copies of the completed referral form, completed recommendation or feedback form, and the team log may suffice for the major part of the record keeping process, if they are completed and filed together for each meeting.

8-03-08 Examples of Forms and Letters

The listed forms may be used with the Team. They are included as sample forms since they have not been assigned form numbers and are not available through Central Supply. Each district or county may reproduce these forms or develop their own forms, if they contain similar information.

Sample Appointment Letter
Sample Confidentiality Agreement
Sample Referral Form
Sample Team Recommendation Form
Sample Feedback on Team Recommendation Form
Sample Case Consultation Log

HS-1262, **Volunteer Enrollment Form** will be used to register team members with the board of claims for liability protection.

The **Feedback on Team Recommendations Form** although optional, will enable staff to give their opinion regarding the effectiveness of the team and the Team's recommendations. Use of such a form will be most useful during the initial year of the team, as it will assist in identifying changes which may be needed in the functioning or composition of the team. Copies of the forms are in Section 9.

SECTION 9

FORMS

SAMPLE APPOINTMENT LETTER

Your response to the Tennessee Department of Human Services' need for consultation on adult protective services situations is appreciated. The multi-disciplinary case review provides Social Services Counselors with a broad base for diagnosing and planning intervention with impaired adults who are abused, neglected, or exploited.

As Adult Protective Services Program Supervisor, I am appointing you to serve as a member of the Multi-Disciplinary Team serving _____ County to advise Protective Service Supervisors and Counselors on adult protective services cases for the term April 1, _____ through May 31, _____.

You will serve in an advisory capacity and the Department of Human Services staff will make all official decisions on the cases which are reviewed by the Team. In accordance with T.C.A. § 9-8-307 (h) you will be registered with the board of claims and will therefore be considered a "volunteer", for purposes of liability protection for acts or omissions within the scope of your duties assigned as a team member except for willful, malicious, or criminal acts or omissions or for acts or omissions done for personal gain.

The Team's recommendations will serve to expedite and strengthen our decision-making process. We look forward to your participation on the Team. Again, thank you for your interest and assistance.

Sincerely,

APS Program Supervisor

ADULT PROTECTIVE SERVICES

MULTI-DISCIPLINARY CASE CONSULTATION TEAM

Confidentiality Agreement

As a member of the Adult Protective Services Case Consultation Team, I will be serving as a volunteer for the Tennessee Department of Human Services in an advisory capacity. I will be reviewing case information related to adults who are receiving Adult Protective Services. This information is confidential and it is protected by State law. I agree to maintain the confidentiality of all such information.

I understand that information obtained through the Team must not be shared outside the Team meetings. This means that any flow of information from the team to any agency or person must be channeled through Department of Human Services staff for approval. This procedure must be followed even if I as a team member represent the agency designated to receive the information.

I have read this agreement and agree to abide by it.

_____ _____

Member Date Witness Date

ADULT PROTECTIVE SERVICES
MULTI-DISCIPLINARY CASE CONSULTATION TEAM

Feedback On Team Recommendations

Please return this form, within 15 working days, to the Team Coordinator.

Case Name: _____ Date Presented: _____

Presented By: _____
Name Title

1. Did the Team quickly grasp the problem? Yes ☐ Somewhat ☐ No ☐

Comment: _____

2. Was the case discussion helpful to you? Yes ☐ Somewhat ☐ No ☐

Comment: _____

3. You wanted to present this case in order to obtain:

Team ideas/input ☐ Support for proposed case decision(s) ☐
Support for case closure ☐ To discuss possible legal action ☐

Other (please explain) _____

4. Were the recommendations made by the Team useful? Yes ☐ Somewhat ☐ No ☐

Explain: _____

5. Do you believe that having such a team is helpful? Yes ☐ Somewhat ☐ No ☐

6. What would you like to change about this Team?

Explain: _____

Thank you for your help in evaluating this process.

ADULT PROTECTIVE SERVICES MULTI-DISCIPLINARY

CASE CONSULTATION TEAM LOG

Date and Review #	Case Name	County	Counselor	Date for Follow-Up	Written Summary

SAMPLE LETTER TO SUBMIT NAME TO TENNESSEE ABUSE REGISTRY

STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
www.state.tn.us/humanserv/
CITIZENS PLAZA BUILDING
400 DEADERICK STREET
NASHVILLE, TN 37248
Telephone 615-313-4700 TTY 1-800-270-1349
Fax 615-741-4165

PHIL BREDESEN
Governor

VIRGINIA T. LODGE
Commissioner

_____
(Date)

Ms. Dorothy Elder, Certification Director
Department of Health, Health Care Facilities
Cordell Hull Building, 1st Floor
425 5th Ave. North
Nashville, TN 37247

Dear Ms. Elder:

In a case investigated by the Tennessee Department of Human Services, Adult Protective Services, the following person has been indicated as a perpetrator of abuse, neglect and/or exploitation of an adult as defined in T.C.A. 71-6-102. Subsequently, the _____ Court of _____ County has granted injunctive relief pursuant to T.C.A. 71-6-104, or has made a finding that the person named is a perpetrator of abuse, neglect and/or exploitation of an adult as defined above. See the attached court order.

Perpetrator's Name: _____

Last Known Mailing Address:

Social Security Number (if known): _____

Name of the facility in which the incident(s) occurred: _____

Position at the facility or role with the adult victim: _____

The person identified in the injunction or named as a perpetrator by the court was found to have committed the following: (Mark only those types of maltreatment which the indicated perpetrator was found to have committed and which were used as a basis for the injunction.)

___ **Abuse:** The infliction of pain, injury, mental anguish, emotional trauma or unreasonable confinement.

___ **Sexual Abuse:** The adult is forced, tricked, threatened or otherwise coerced into sexual activity, involuntary exposure to sexually explicit material or language, or sexual contact against his/her will. Or the adult, as defined in law, is unable to give consent to such sexual activities or contact, and is engaged in such activities or contact with another person. Sexual abuse may occur regardless of whether or not the perpetrator is the spouse of the victim.

___ **Neglect:** The omission of services/care needed by an adult to prevent physical or mental injury/illness.

___ **Exploitation:** The improper use by a caretaker of funds which have been paid by a governmental agency to an adult or the caretaker for the use or care of the adult.

A certified copy of the court order is attached.

Sincerely,

Social Counselor
Adult Protective Services
TN Dept. of Human Services

Department of Human Services
ADULT PROTECTIVE SERVICES INTAKE

Intake Date	Time of Referral	Intake Counselor	Intake Site	Referral County

Previous Case	Case Status	Date Closed	Case Number	ACSS Date
☐ yes ☐ no	☐ open ☐ closed			

☐ Screen Out	Screen Out Date	By Whom	Screen Out Reason

☐ Intake Assigned	Assigned Date	Unit #	Assigned Counselor

ASSIGNMENT STATUS: - Priority Register: NO	TYPE OF REFERRAL: ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Neglect ☐ Self Neglect ☐ Financial Exploitation

NAME OF CLIENT I	DOB	AGE	SSN	SEX	RACE
				☐ M ☐ F	☐ Cau. ☐ Hisp ☐ Afr.Amer ☐ Asian ☐ Amer. Ind ☐ Unk

NAME OF CLIENT II	DOB	AGE	SSN	SEX	RACE
				☐ M ☐ F	☐ Cau. ☐ Hisp ☐ Afr.Amer ☐ Asian ☐ Amer. Ind ☐ Unk

CLIENT LOCATION: ☐ HOME ☐ NURSING HOME ☐ GROUP HOME ☐ HOSPITAL ☐ OTHER

Specify name of nursing home, group home, hospital or other:

CLIENT'S RESIDENTIAL ADDRESS:	CITY, STATE, ZIP

DIRECTIONS TO HOME:	TELEPHONE NUMBER:

CONTACT INFORMATION:
(Relatives, Pharmacy, Neighbors, Emergency Contacts, Agencies Providing Services, POA's, Significant Others)

NAME	RELATIONSHIP	ADDRESS/PHONE	IN HOME
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

REFERENT SOURCE:
NAME/RELATIONSHIP:
ADDRESS/PHONE: ☐ In Home

CLIENT I :	INCOME: $ INSURANCE:	INCOME SOURCES:
PHYSICIAN INFORMATION:		
CLIENT IS UNABLE TO PROTECT HIS/HER OWN INTERESTS DUE TO: ☐ **PHYSICAL IMPAIRMENT** ☐ **MENTAL IMPAIRMENT** ☐ **AGE/ELDERLY** ☐ **NO IMPAIRMENT EXISTS**		
MEDICAL INFORMATION: PHYSICAL AND MENTAL HEALTH CONDITIONS: ☐ CLIENT NEEDS TOTAL CARE ☐ CLIENT NEEDS LIMITED CARE		MEDICATIONS (IF KNOWN)
ADL'S OR THINGS CLIENT CAN/NOT DO:		
THREAT OF HARM: ALLEGATIONS REGARDING ABUSE, NEGLECT, EXPLOITATION OR SELF-NEGLECT: (WHAT, WHEN, WHERE, HOW, NEEDS OF CLIENT WHICH ARE UNMET, HOW LONG SITUATION HAS EXISTED, ETC.)		
ALLEGED PERPETRATOR(S): NAME/RELATIONSHIP: ADDRESS/PHONE: ☐ In Home		

ADDITIONAL INFORMATION: Include information for both Client I and Client II regarding witnesses to Abuse/ Neglect, reporter's expectations of DHS, dangers to APS staff, physical description of client if needed, etc.:

CLIENT II :	INCOME: $ INSURANCE:	INCOME SOURCES:
PHYSICIAN INFORMATION:		
CLIENT IS UNABLE TO PROTECT HIS/HER OWN INTERESTS DUE TO: ☐ **PHYSICAL IMPAIRMENT** ☐ **MENTAL IMPAIRMENT** ☐ **AGE/ELDERLY** ☐ **NO IMPAIRMENT EXISTS**		
MEDICAL INFORMATION: PHYSICAL AND MENTAL HEALTH CONDITIONS: ☐ CLIENT NEEDS TOTAL CARE ☐ CLIENT NEEDS LIMITED CARE		MEDICATIONS (IF KNOWN)
ADL'S OR THINGS CLIENT CAN/NOT DO:		
THREAT OF HARM: ALLEGATIONS REGARDING ABUSE, NEGLECT, EXPLOITATION OR SELF-NEGLECT: (WHAT, WHEN, WHERE, HOW, NEEDS OF CLIENT WHICH ARE UNMET, HOW LONG SITUATION HAS EXISTED, ETC.)		
ALLEGED PERPETRATOR(S): NAME/RELATIONSHIP: ADDRESS/PHONE: ☐ In Home		

(HANDWRITTEN VERSION)

Department of Human Services
ADULT PROTECTIVE SERVICES INTAKE

Intake Date	Time of Referral	Intake Counselor	Intake Site	Referral County

Previous Case	Case Status	Date Closed	Case Number	ACSS Date
☐ yes ☐ no	☐ open ☐ closed			

☐ Screen Out	Screen Out Date	By Whom	Screen Out Reason
			☐ No A/N/E ☐ No A/N/E, ref. to other serv. ☐ No impairment ☐ No impairment, ref. to other serv. ☐ No ANE/ impairment ☐ No ANE/ impair., ref. to other serv. ☐ MH/DD Licensed and Operated Facility

☐ Intake Assigned	Assigned Date	Unit #	Assigned Counselor

ASSIGNMENT STATUS:	TYPE OF REFERRAL:
☐ A ☐ B ☐ C ☐ D Priority Status: ☐ Yes ☐ No	☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Neglect ☐ Self Neglect ☐ Financial Exploitation

NAME OF CLIENT I	DOB	AGE	SSN	SEX	RACE
				☐ **M** ☐ **F**	☐ **Cau.** ☐ **Hisp** ☐ **Afr.Amer** ☐ **Asian** ☐ **Amer. Ind** ☐ **Unk**

NAME OF CLIENT II	DOB	AGE	SSN	SEX	RACE
				☐ **M** ☐ **F**	☐ **Cau.** ☐ **Hisp** ☐ **Afr.Amer** ☐ **Asian** ☐ **Amer. Ind** ☐ **Unk**

CLIENT LOCATION: ☐ HOME ☐ NURSING HOME ☐ GROUP HOME ☐ HOSPITAL ☐ OTHER

Specify name of nursing home, group home, hospital or other:

CLIENT'S RESIDENTIAL ADDRESS:	CITY, STATE, ZIP

DIRECTIONS TO HOME:	TELEPHONE NUMBER:

CONTACT INFORMATION:
(Relatives, Pharmacy, Neighbors, Emergency Contacts, Agencies Providing Services, POA's, Significant Others)

NAME	RELATIONSHIP	ADDRESS/PHONE	IN HOME
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

REFERENT SOURCE:
NAME/RELATIONSHIP:
ADDRESS/PHONE: ☐ In Home

CLIENT I :	INCOME: $ INSURANCE:	INCOME SOURCES: ☐ Alimony/Child Support ☐ Supplemental Sec. Income (SSI) ☐ Social Security Disability ☐ Retirement Pension ☐ Social Security Retirement (SSA) ☐ Trust Fund ☐ None ☐ Veterans ☐ Work ☐ Other _____

PHYSICIAN INFORMATION:

CLIENT IS UNABLE TO PROTECT HIS/HER OWN INTERESTS DUE TO:

☐ **PHYSICAL IMPAIRMENT** ☐ **MENTAL IMPAIRMENT** ☐ **AGE/ELDERLY** ☐ **NO IMPAIRMENT EXISTS**

MEDICAL INFORMATION: PHYSICAL AND MENTAL HEALTH CONDITIONS: ☐ CLIENT NEEDS TOTAL CARE ☐ CLIENT NEEDS LIMITED CARE	MEDICATIONS (IF KNOWN)

ADL'S OR THINGS CLIENT CAN/NOT DO:

THREAT OF HARM: ALLEGATIONS REGARDING ABUSE, NEGLECT, EXPLOITATION OR SELF-NEGLECT:
(WHAT, WHEN, WHERE, HOW, NEEDS OF CLIENT WHICH ARE UNMET, HOW LONG SITUATION HAS EXISTED, ETC.)

ALLEGED PERPETRATOR(S):
NAME/RELATIONSHIP:
ADDRESS/PHONE: ☐ In Home

ADDITIONAL INFORMATION:
Include information for both Client I and Client II regarding witnesses to Abuse/ Neglect, reporter's expectations of DHS, dangers to APS staff, physical description of client if needed, etc.:

CLIENT II :	INCOME: $ INSURANCE:	INCOME SOURCES: ☐ Alimony/Child Support ☐ Supplemental Sec. Income (SSI) ☐ Social Security Disability ☐ Retirement Pension ☐ Social Security Retirement (SSA) ☐ Trust Fund ☐ None ☐ Veterans ☐ Work ☐ Other _____

PHYSICIAN INFORMATION:

CLIENT IS UNABLE TO PROTECT HIS/HER OWN INTERESTS DUE TO:
☐ **PHYSICAL IMPAIRMENT** ☐ **MENTAL IMPAIRMENT** ☐ **AGE/ELDERLY** ☐ **NO IMPAIRMENT EXISTS**

MEDICAL INFORMATION: PHYSICAL AND MENTAL HEALTH CONDITIONS: ☐ CLIENT NEEDS TOTAL CARE ☐ CLIENT NEEDS LIMITED CARE	MEDICATIONS (IF KNOWN)

ADL'S OR THINGS CLIENT CAN/NOT DO:

THREAT OF HARM: ALLEGATIONS REGARDING ABUSE, NEGLECT, EXPLOITATION OR SELF-NEGLECT:
(WHAT, WHEN, WHERE, HOW, NEEDS OF CLIENT WHICH ARE UNMET, HOW LONG SITUATION HAS EXISTED, ETC.)

ALLEGED PERPETRATOR(S):
NAME/RELATIONSHIP:
ADDRESS/PHONE: ☐ In Home

ADULT PROTECTIVE SERVICES
INFORMATION AND INTAKE
HS-0055

SPECIFIC INSTRUCTION:

Intake Date, Time of Referral, Intake Counselor and Intake Site are self-explanatory. The Intake Site field is a drop down box with the four intake sites listed. The appropriate one should be chosen. This field can be entered before saving the form on the computer so it will not have to be repeated. It can however be changed at any time.

Referral County is the county where the referral is either assigned or screened out.

Previous Case: After checking the ACSS, check yes or no if there had been a case before on primary client.

Case Status: If there has been a previous case, check if the case is still open or active or if it is a closed case.

Date Closed: If the previous case is closed, then put in the closed or rejected date.

Case Number and ACSS Date: Enter this information after assigning the case on ACSS.

Screen Out and Intake Assigned: Check the appropriate box determining if the decision is made to screen out the referral or assign it.

Screen Out Date and Assigned Date are the dates the referral is either screened out or assigned to a counselor for investigation.

By Whom is the staff who made the screen out decision. **Screen Out Reason** is the reason for screening out the referral-it must meet one of the seven (7) criteria for screen-out in the drop-down box on the form.

Unit # is the District number of the counselor to whom the referral is assigned.

Assigned Counselor is the name of the investigative staff person to whom the referral is assigned.

Assignment Status is assigned based on the level of risk alleged in the referral, according to the *Assignment Status Guidelines* in the APS Policy Manual, Section 2-08. There is a drop-down box on the (electronic) form from which to choose the appropriate status. All **A** and **B** status referrals are assigned immediately by the intake counselor. Assignment status **A** referrals require immediate response from the investigative counselor.

Priority Register should be marked yes if the referral is placed on a priority register otherwise the default is no and should not be changed.

SECTION 9

Type of Referral: Check all that apply based on the allegations made in the referral.
Client Identifying Information: There are boxes to include identifying information for **Client I** and **Client II**. This will only pertain to married individuals in the same case. List one spouse as Client I and the other as Client II. After putting in client's name, check if client is the **alleged perp**. This may happen if the referral includes husband and wife and one of clients is abusing the other. Put in appropriate **date of birth** (if known), **age** and **social security number** of client. Check the appropriate boxes for **sex** and **race**. Race abbreviations are as follows: Cau-Caucasion, Hisp-Hispanic, Afr. Amer-African American, Asian-Asian, Amer. Ind-American Indian and Unk-Unknown.

Client Location: Check the appropriate box of where client is currently residing. Specify the name of the nursing home, group home, hospital or other facility where the client may be located.

Client Address, Direction To Home and Telephone Number is self-explanatory.

Contact Information: This is detailed information to include on any significant contact resources that client may have. List any pharmacy, neighbors, friends, POA's, relatives, emergency contacts, agencies providing any services and any significant others involved with client. If the contact lives in the home, then check the **In Home** box at the end of the line.

Referent Source: Enter the correct referent information in the space provided. If the referent lives in the home check **In Home** at the end of the line.

Client I: Enter the name of client that was entered in Client I on the first page. All of the following information will pertain to Client I.

Income and Income Sources are self-explanatory. Income Sources have drop down boxes with types of income to choose from. There are three boxes available for this information. List any additional sources in additional information.

Client is unable to protect his/her own interests due to: Check any **impairment** that may apply. If there are no impairments, check **No Impairment Exists** for screen out purposes.

Medical Information: List or describe any **physical and mental health conditions**. List any **Medications** if known. Check **Client Needs Total Care** and **Client Needs Limited Care** If the referent believes client needs total or limited care. Total care is care that involves assistance with all ADLs and may require 24-hour supervision. Limited care is care that client needs assistance with. Client may be able to complete some ADLs such as personal care, feeding and bathing but may need assistance with cleaning, running errands or ambulating.

ADLs or Things Client Can/Not Do: List ADLs client can or cannot do. For example, is client able to ambulate or communicate with others? Is client able to cook, clean or feed self?

Threat of Harm: Allegations Regarding Abuse, Neglect, Exploitation or Self-Neglect: Details regarding the harm or risk of harm to the client. This section states the details of the abuse, neglect, exploitation or self-neglect. Include specific information regarding what has happened to the adult, when it occurred, how often, where it happened, how the abuse/neglect occurred, who was involved in the A/N, what are the client's unmet needs and how long the situation has existed. Include all relevant information.

Alleged Perpetrator(s): Enter the correct referent information in the space provided. If the perpetrator lives in the home check **In Home** at the end of the line.

Additional Information: Include any additional information for Client I and Client II that will assist the counselor investigating the referral. Include witnesses to A/N, Referent's expectations of DHS, Dangers to APS Staff, Physical description of Client if needed and any other significant information.

Client II: This information will pertain to the impairment and details of A/N for Client II. If there is not a Client II, this section will remain blank and page can be discarded.

TENNESSEE DEPARTMENT OF HUMAN SERVICES

MEDICAL REPORT - ADULT FAMILY HOME

☐ Applicant/Sponsor is to provide care for adult(s) ☐ Information is for the "Other person living in the home"

Name: _____ Birth Date: _____

Address: _____

Specify your relationship to the other persons living in the home: _____

I hereby authorize (see the attached form: Authorization for Release of Information {HS-2832}) the physician named below to release information to the Department of Human Services, which is necessary to complete the adult family home evaluation and the adult's placement in the home.

Physician's Name: _____

Address: _____

_____

EXAMINATION

General Physical Condition:

_____

_____

Tuberculin Test Results: _____ HIV Test Results: _____

Other Tests & Results: _____

_____

☐ (Sponsor) Specify if patient has any communicable disease or chronic condition, which would keep him/her from caring for an adult(s) in the home. Specify any physical, mental, or emotional problems, which would affect this person's ability to care for an adult(s).

☐ ("Other adult living in the home") Indicate conditions detrimental to the adult's placement in home:

_____

_____

_____

This information is in compliance with HIPAA regulations. The individual has received DHS Privacy Notice.

(Applies to Sponsor only) On the basis of this examination and my knowledge of this patient, I recommend ☐; I **do not** recommend ☐ him/her as a sponsor to provide care for adults.

Comments: _____

_____

Signed: _____ M.D. Date: _____

Address: _____

PLEASE RETURN TO:

Name: _____

Address: _____

_____

County: _____
Date: _____

TENNESSEE DEPARTMENT OF HUMAN SERVICES

REPORT OF PHYSICIAN'S EXAMINATION
FOR
RESIDENT OF FAMILY HOME FOR ADULTS

To the Physician:

Family Homes for Adults are for people who, because of physical, mental, or emotional limitations are unable to live independently in the community (not for people who need skilled nursing care) but can benefit from the support and security of family living.

This examination and recommendation will help determine if care in a family home is appropriate for the person listed below at this time.

- The patient is responsible for payment of the examination, if Medicaid or Tenncare disapproves.
- DHS cannot authorize payment for the examination.

PHYSICIAN'S STATEMENT

See the attached Authorization for Release of Information Form

Name of the Resident/Potential Resident: _____

1. General state of health: Good _____ Fair _____ Poor _____ Very Poor _____
2. Does patient have any communicable disease or chronic condition that might be harmful to others living in the same household with him/her?

   No ☐ Yes ☐ If yes, describe _____

   _____
3. Is patient under treatment? No ☐ Yes ☐ If yes, for what condition? _____

   _____
4. Is patient on medication? No ☐ Yes ☐ If so, who has the medicine or prescriptions and instructions?

   _____

   _____
5. Patient needs a special diet? No ☐ Yes ☐ If yes, what type? _____

   _____
6. Patient is able to care for personal needs with little ☐ No ☐ assistance.
7. What specific help will patient need from others? Describe here or attach instructions. _____

   _____
8. In my opinion this patient can ☐ cannot ☐ be given suitable care in a family home.

This information is in compliance with HIPAA regulations. The individual has received the DHS Privacy Notice.

_____ _____
Signature of Physician Date

Tennessee Department of Human Services

APPLICATION TO PROVIDE A FAMILY HOME FOR ADULTS

APPLICANT'S DATA

Name (Female) _____
Last First Maiden

SS#: _____ Birthdate: _____ Race: _____

Name (Male) _____
Last First Middle

SS#: _____ Birthdate: _____ Race: _____

Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____

Directions for reaching home _____

Present Employment and Income

Occupation (Female)		Occupation (Male)	
Employer		Employer	
Address		Address	
How long employed		How long employed	
Monthly income		Monthly income	
Other income		Other income	
Total monthly Income		Total monthly income	

Marriage: Place _____ Date _____

Previous Marriage(s)

Female: Place _____ Date _____
Female: Place _____ Date _____
Male: Place _____ Date _____
Male: Place _____ Date _____

OTHER MEMBERS OF THE HOUSEHOLD

Name	Birthdate	Relationship to Applicant	Occupation or grade in school

I/We wish to care for the:

Aged _____ Disabled _____ Number of Residents _____
Male _____ Female _____ Either Sex _____ (Complete each applicable item.)

Long Term Family Home Care _____ Emergency Family Home Care _____

Type of Housing: One Family _____ Duplex _____ Apartment _____ Trailer _____

Monthly Rent or Mortgage $ _____

Total Number of Rooms _____

Total Number of Bedrooms _____

Total Number of Bathrooms _____

Total Number of Bedrooms available for Residents: (Ground Level) _____ Second Level _____

Neighborhood Facilities and Services (Check all which are applicable).

City Bus	___	Adult Day Activity Center	___	Recreational Centers	___	Houses of Worship: Catholic	___
Taxi	___	Movies	___	Senior Citizens or Similar Group	___	Jewish	___
		Parks, other	___	Shopping Centers	___	Protestant (Indicate Denominations)	___ _____
						Other	___ _____

How did you become interested in family home care for adults? _____

_____

_____

State any previous experience or training in making a home for adults. _____

_____

_____

State any specialized training completed _____

_____

_____

References: Please list three persons, at least one of whom is unrelated to you.

Name			
Address			
City, State, Zip			
Work Phone			
Home Phone			
Relationship			

The above statements are correct to the best of my knowledge.

Signature of Applicant (s)

_____ Date _____

_____ Date _____

When completed return to:

_____ County _____

_____ Date Given _____

_____ Date Returned _____

_____ Case Number _____

ADULT PLACEMENT CONTRACT
between
The State of Tennessee, Department of Human Services,
Residents and Approved Sponsor(s) to Provide Family Homes for Adults

This contract sets forth the agreement reached between the State of Tennessee, Department of Human Services, hereinafter referenced as "Department", approved Sponsor(s) and Resident, as identified below in Section A, for placement of an adult in a family home.

A. PARTIES

Approved Sponsor(s),

_____ and/or _____
(sponsor) (sponsor)

_____ _____
Social Security Number Social Security Number

_____
APS Sponsor Number Street, Route, Box No. City State Zip
On
_____
Resident's Name Birth Date Case No Date of Placement
.

Department Representative: _____ Title: _____

B. RESPONSIBILITIES OF DEPARTMENT

The Department, in County, through its undersigned representative, agrees as follows:

B.1. To arrange for transportation that may be required for special medical or other special needs of the Resident and that may include reimbursing the Sponsor for mileage in accordance with the State's Comprehensive Travel Regulations;

B.2. To consult with Sponsor (s) and the Resident on a regular basis, at a minimum of one (1) consultation for each three (3) month period of residency in the placement home, and to assist each in matters relating to the placement;

B.3. To assist the Sponsor (s) and Resident in emergency situations which require relief help or immediate change of residency of the Resident; and

B.4. To assist the Resident in relocating when it is necessary on behalf of the Sponsor(s) or the Resident that other arrangements be made.

C. RESPONSIBILITIES OF SPONSOR(S)

Sponsor(s), having been approved to provide a family home for adults, agrees as follows:

C.1. To accept the above identified resident for care in Sponsor home. While in Sponsor home as a Resident he/she will be treated as a member of the Sponsor family with access to all facilities of Sponsor home;

C.2. To provide assistance or supervision as recommended by the Resident's attending physician and/or mental health provider;

C.3. To provide or arrange for transportation as necessary for routine medical care and for the Resident's participation in community activities and submit documentation as needed for special transportation provided for the Resident;

C.4. To provide family home care only for adults whose placement is arranged through the Department. Sponsor(s) further agrees to accept no other persons into Sponsor home on a continuing basis without prior approval of the Department and understand that approval cannot be given to provide foster care for children nor for placement of adults through another agency;

C.5. That an approved Sponsor as identified in Section A will be available in the home when the Resident is present except for relief help or short absences, as agreed upon in advance with the Department;

C.6. To consult with the Department representative on a regular basis and to bring to the Department Representative's immediate attention any matters which affect this placement;

C.7. To reimburse the Resident and the Department all funds received as overpayment resulting from any cause;

C.8. To notify the Department and the designated relative or friend as identified in Section D.5. of this agreement of any emergency situation related to the Resident;

C.9. To ensure that strict standards of confidentiality of records and information regarding the Resident be maintained in accordance with both applicable federal and state law. All material and information regarding the Resident, regardless of form, medium or method of communication, provided to the Sponsor(s) by the Department or acquired by the Sponsor(s) and provided to the Department shall be regarded as confidential information. Such information shall not be disclosed, and all necessary steps shall be taken by the Sponsor(s) to safeguard the confidentiality of such material or information in conformance with applicable federal and state law, state and federal rules and regulations, State policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Sponsors to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy and ethical standards;

C.10. To warrant that Sponsor(s) is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations and will comply with all applicable HIPAA requirements in the course of this contract. Sponsors warrant that they will cooperate with the Department in the course of performance of the contract so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. Sponsor(s) will sign any documents that are reasonably necessary to keep the Department and Sponsors in compliance with HIPAA, including, but not limited to, business associate agreements; and

C.11. That State employees and officers may provide Adult Foster Care Services pursuant to this Contract only by the authority of an exemption granted to the Department of Human Services by the Commissioner of Finance and Administration. If such exemption is not in effect at the time of the execution of this Contract, any person who is an employee or officer of the State of Tennessee may not enter into this Contract for the provision of those services. Neither the Department of Human Services nor the State of Tennessee shall be liable for payments to such persons without the granting of an exemption for those persons.

C.12. Sponsor(s) will provide the recommended daily care of the Resident accepted and placed in the home and develop appropriate procedures to account for those personal items and funds entrusted to the Sponsor by the Resident.

C.13. Sponsor(s) will abide by regulations and standards for family home care as stated in the Department's policy. Sponsor(s) will maintain good physical standards in the home giving consideration to the safety, light, heat, ventilation, cleanliness and sanitation, and to comply with regulations concerning these matters.

C.14. Sponsor(s) will allow the Representative of the Department to visit the home at any reasonable time. Sponsor(s) will observe and share information about the well being of the Resident with the Department's Representative and will provide the opportunity for the Department's Representative to interview the Resident in private, upon request.

C.15. Sponsor(s) will accept supervision by the Department and cooperate with the Department's Representative by following suggestions and recommendations regarding the health and well-being of the Resident.

C.16. Sponsor(s) will accept the decision of the Department's Representative to remove a Resident when, in the Representative's opinion, such removal is necessary.

C.17. Sponsor(s) will report to the Department any change of address or any serious/continued illness in the Sponsor household.

C.18. Sponsor(s) hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this contract on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

C.19. Sponsor(s) will give thirty (30) days notice to the Department if the sponsor(s) decides not to continue to keep a Resident.

D. RESPONSIBILITIES OF RESIDENT

In accepting placement in the above identified approved Family Home for Adults, Resident agrees:

D.1. To participate in family activities to the extent possible;

D.2. To use facilities of the home as other members of the family with due regard to their needs as well as Resident's own needs;

D.3. To accept the assistance and supervision of the Sponsors as recommended by Resident's physician and/or mental health provider;

D.4. To consult regularly with the Department Representative about any concerns and to bring to the Representative's immediate attention matters which affect continuation of the placement; and

D.5 To designate, if possible, a person to be notified in case of emergency.

Designated Person:

_____

Name Address Phone No.

Relationship to Resident: _____

E. CONTRACT TERM

This Contract shall be effective upon execution of the Contract and shall be terminated in accordance with Section G.

F. PAYMENT METHODOLOGY

F.1. Sponsors shall be compensated by the Department in the form of payment for services at a rate of $_____ monthly for the duration of this contract. The Sponsors shall not be compensated for any travel time related to this Contract. A "month" shall be defined as a calendar month. If this contract is terminated during any portion of a month, Sponsors may be paid on a pro rata basis for such period of that month as they have provided family home placement for above Resident.

F.2. Resident will pay board in the amount of $ _____ monthly to the Sponsor(s), plus $ _____ as payment for services. Total monthly payment for the duration of this contract from the Resident to the Sponsor(s)shall equal $_____. If this contract is terminated during any portion of a month, Sponsor(s) may be paid on a pro rata basis for such period of that month as he or she has provided family home placement for above Resident.

F.3. The sponsor may be compensated for mileage in providing special transportation for the Resident at the rate authorized by the State's Comprehensive Travel Regulations.

G. TERMINATION OF CONTRACT

G.1. Termination for Convenience. This Contract may be terminated by the Department by giving written notice to the Sponsor(s), with a minimum of at least thirty (30) days before the effective date of termination. Should the Department exercise this provision, the Sponsor(s) shall be entitled to compensation in accordance with Section E for all satisfactory and authorized services completed as of the termination date. In the event of disagreement, Sponsor(s) may file a claim with the Tennessee Claims Commission in order to seek redress.

G.2. Termination by Default. In the event that Sponsor(s) fails or becomes unable to perform the responsibilities under the terms of this Contract, or if the Sponsor(s) violates any terms of this Contract, the Department may immediately terminate this Contract and withhold payments in excess of fair compensation. Termination shall be effective upon the date of removal of the Resident from Sponsor(s) family home. If such termination occurs, the Sponsor(s) shall be entitled to compensation in accordance with Section E for all satisfactory and authorized services completed as of the termination date in accordance with Section E.

G.3. Hold Harmless. The Sponsor(s) agrees to indemnify and hold harmless the State of Tennessee as well as the Department, its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Sponsor(s), Sponsor(s) employees, or any person acting for or on Sponsor(s) behalf relating to this Contract. The Sponsor(s) further agrees he/she shall be liable for the reasonable cost of attorneys for the State or the Department in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Sponsor(s) to the State or Department.

In the event of any such suit or claim, the Sponsor(s) shall give the State and/or Department immediate notice thereof and shall provide all assistance required by the State in the State and/or Department's defense. The State shall give the Sponsor(s) written notice of any such claim or suit, and the Sponsor(s) shall have full right and obligation to conduct the Sponsor's own defense thereof. Nothing contained herein shall be deemed to accord to the Sponsor(s), through its attorney(s), the right to represent the State of Tennessee in any legal matter, such rights being governed by ***Tennessee Code Annotated***, Section 8-6-106.

SIGNATURES

By affixing our signatures hereto, each party affirms the terms of the contract and confidence in the other parties to fulfill the responsibilities thereof.

Entered into this _____ day of _____, 20_____.

_____ Sponsor	_____ Resident
_____ Sponsor	_____ Department Representative
_____ Witness to Mark	_____ Supervisor
_____ Witness to Mark	_____ Address
	_____ Phone No. (Office)
	_____ Phone No. (Home)

Original to:
Foster Home Case File

Copy to:
Sponsors
Resident
Fiscal Services

Date terminated:

_____ Vendor No. _____ Contract No.

ATTACHMENT #1 TO HS-0071 - ADULT PLACEMENT CONTRACT

This attachment is incorporated in the Adult Placement Contract, HS-0071 and made a part thereof:

State employees and officers may provide Adult Foster Care Services pursuant to this Contract only by authority of an exemption granted to the Department of Human Services by the Commissioner of Finance and Administration. If such exemption is not in effect at the time of the execution of this Contract, any person who is an employee or officer of the State of Tennessee may not enter into this Contract for the provision of those services and neither the Department of Human Services or the State of Tennessee shall not be liable for payments to any such persons without the granting of the exemption for those persons.

_____
Date:

_____
Adult Foster Care Service Contractor

_____
Adult Foster Care Service Contractor

_____
Date

_____
Representative of the Department of Human Services

TENNESSEE DEPARTMENT OF HUMAN SERVICES

Report of Alleged Abuse, Neglect or Exploitation of an Adult

To:

The Department of Human Services has received a report of abuse, neglect, or exploitation of an adult which is being reported to you in accordance with the Tennessee Adult Protection Act (Tennessee Code Annotated 71-6-103) which states,

> "Upon receipt of the report the department shall take the following action:
>
> (1) Notify the appropriate law enforcement agency in all cases in which the report involves abuse, neglect or exploitation of the adult by another person or persons.
>
> (2) Notify the appropriate licensing authority if the report concerns an adult who is a resident of…. a residential facility…"

The following report was received by DHS on: Date: ___/___/_____

Name: Phone #: Age: Sex:

Address: Zip: County:

Reported to be: Abused ☐ Neglected ☐ Exploited ☐

Alleged Perpetrator: Name: Relationship to Adult:

Address:

Allegation:

Due to the emergent nature of this report information was given to you by telephone: Yes ☐ No ☐ Date: ___/___/

Report sent to: Law Enforcement ☐ TDH ☐ TDMH/DD ☐ TBI ☐

Law Enforcement Intervention: Requested ☐ At your discretion ☐

Assigned to Counselor: ☐ Name: To be assigned: ☐

Will not be investigated by APS: ☐

Comments:

Report submitted by: Date: ___/___/

County: Phone #:

Approved by: Date: ___/___/

Attachment: Yes ☐ No ☐

FORM HS-0875 (1215) REPORT OF ALLEGED ABUSE, NEGLECT OR EXPLOITATION OF AN ADULT TO LAW ENFORCEMENT OR THE APPROPRIATE LICENSING AUTHORITY

I. General Instructions

A. Purpose

The HS-0875 (1215) is a form letter designed for use by APS to make the following reports:

-Report to law enforcement referrals received by our Department alleging abuse, neglect or exploitation of adults by another person or persons.

– Report to the appropriate licensing authority referrals concerning adults who are residents of a nursing home, homes for the aged or residential homes for the aged licensed by the TN Department of Health or a residential facility operated for the provision of mental health or mental retardation services licensed by the TN Department of Mental Health and Developmental Disabilities.

– Report to the TN Bureau of Investigation referrals alleging abuse, neglect or exploitation:

- of an adult who is a resident of a Medicaid-funded facility;
- of an adult who is a resident of a Board and Care facility regardless of whether the facility receives Medicaid funds, but the adult is a TennCare recipient;

and

- there is physical evidence, an eyewitness, or a pending medical report which may document physical evidence;
- the alleged abuse or neglect was potentially life-threatening or involved:
  - serious bodily injury,
  - any type of sexual assault,
  - death;
- an allegation of verbal abuse that caused the adult to reasonably fear imminent bodily injury.

See **Section 2-11, 2-12** and **2-13** regarding Notifications.

These reports are made to comply with the Adult Protection Act (TCA 71-6-103).

The form is available electronically on the Department of Human Services Intranet.

B. Initiation of Form

Form 0875 (1215) should be completed in duplicate and one (1) copy of the form retained in the case record for each agency notified – Law Enforcement, TN Department of Health, TN Department of Mental Health and Developmental Disabilities (DMH/DD), or TN Bureau of Investigation.

II. Specific Instructions

1. Address the form to the appropriate County Law Enforcement Officer (Police or Sheriff); or as appropriate, to the Department of Health – Regional Offices when the report concerns residents of Homes for the Aged (**Section 11**, Appendix); the Department of Mental Health/ Developmental Disabilities – Regional Offices when the report concerns residents of facilities receiving mental health or mental retardation services (**Section 11**, Appendix); or the TN Bureau of Investigation – Regional Offices (**Section 11**, Appendix).

2. State the date the referral was received by DHS.

3. State the name, address, telephone number, age and sex of the adult client who was referred to our Department.

4. Check the appropriate type of report (may be more than one).

5. State the name of the person alleged to have caused the reported condition of the client. State the address of this person and his/her relationship to the adult client.

6. Explain the basic allegations made regarding the client's condition and how the abuse, neglect or exploitation reportedly occurred.

7. In emergencies where law enforcement, TDH, DMH/DD or TBI were notified immediately by telephone, write in the date of the telephone report.

8. Check all entities to whom the report is being sent.

9. Check whether or not law enforcement intervention is requested (believed to be needed), or intervention is at their discretion.

10. Write the name of the investigative counselor to whom the referral was assigned. If the referral has not been assigned for investigation, check the box "To be assigned".

11. Include comments as deemed necessary.

12. State name of counselor (staff person) completing and submitting the report and date completed.

13. State name of person approving the report and date approved.

14. State the county office and the telephone number of the counselor submitting the form.

15. Check Yes or No whether there are any attachments.

Note: Care must be taken when providing information on the 0875 (1215) to never reveal the source of the information (identity of the reporter).

Tennessee Department of Human Services

FINANCIAL INFORMATION FOR ADULT FAMILY HOME SPONSOR(S)

This information is needed to provide us an understanding of how you manage your income as a part of the total picture of your family life. Many of the items listed below may not be met on a monthly basis, and for these it may be convenient to calculate the yearly amount and divide by 12. For items that do not apply to you, please list "not applicable" (N/A) in the provided blank.

MONTHLY FAMILY INCOME

Sponsor's gross income from regular employment		$ _____
Spouse's gross income from regular employment		$ _____
Additional income (Give source) _____		$ + _____
	Sub-Total	$ _____
Deductions: (Give source) _____ (Insurance, FICA, Withholding, etc.)		$ - _____
(Gross income less deductions)	**TOTAL**	$ _____

MONTHLY FAMILY EXPENSES

Food	$ _____	Home Maintenance: (yard, minor repairs, etc.)	$ _____
Clothing	$ _____		
House payments	$ _____	Household operations: (childcare, laundry, maid, supplies, etc.)	$ _____
Rent	$ _____		
Home improvements	$ _____	Automobile payments	$ _____
Utilities: (electricity, gas, water, etc.)	$ _____	Auto operation and upkeep	
Coal, oil, or firewood	$ _____	Insurance: (homeowners or renter's, medical, car, and/or life)	$ _____
Telephone	$ _____	Amusement and education: (movies, newspapers, clubs, sports, etc.)	$ _____
Savings account	$ _____		
Medical and dental	$ _____		
Church	$ _____	Other monthly expenses	$ _____
Charity	$ _____		
		TOTAL	$ _____

ESTIMATE BELOW THE AMOUNT OF YOUR DEBTS

Item	Amount Financed	Amount of Payment	How Often Paid	When was Debt Incurred	When Will it be Paid

The above information is correct to the best of my knowledge.

Signature _____ (Sponsor) (Date)

Signature _____ (Spouse) (Date)

TENNESSEE DEPARTMENT OF HUMAN SERVICES
CLOSED ADULT PROTECTIVE SERVICES CASES INPUT FORM

Case #: ____|____|____|____|____|____|____|____|____|____|____|____

Indv. Last Name: ____|____|____|____|____|____|____|____|____|____|____|____|____|____

Indv. First Name: ____|____|____|____|____|____|____|____|____|____|____ Indv. Middle Initial: ____|____

1) (REFERRAL BY) Referral Made By: (Circle One)

A. Self
B. Spouse
C. Relative(s)
D. Neighbor
E. Other social agency staff
F. Hospital social worker
G. Doctor/Nurse
H. Friend
I. Law Enforcement
J. DHS Staff
K. Anonymous
L. Other

2) (REFRL PRIORITY) Referral was an: (Up to 3)

A. **Emergency:** alleged imminent danger of irreparable harm or death
B. **Emergency:** abused or seriously ill, no allegation of imminent danger of irreparable harm or death
C. **Non-emergency:** poor physical health, unable to meet basic needs
D. **Non-emergency:** poor mental functioning, unable to meet basic needs
E. Eviction
F. Abandoned or wandering with no residence
G. Other

3) (INVSTIGATN START) After DHS receives the referral, investigation was initiated within (working days) (Circle one):

A. 0 to 3 hours
B. 1 day
D. 1 week
E. 2 weeks
F. 3 weeks
G. More than 3 weeks

4) (LIVING ARANGMNT) When case was opened (last time) the adult was living: (Circle one)

A. Alone
B. With relative(s) and/or spouse
C. Mental health or mental retardation institution
D. Nursing home
E. Boarding, group or foster home
F. Hospital
G. Non-relatives

5) (OVERTIME) Case required work after regularly scheduled working hours (work day or weekends) during the case was open: (Circle one)

Y. Yes N. No U. Uknown

6) Total number of case contacts made (first 60 days):

6)A. (PHONE CALLS) Phone calls _____
6)B. (HOME VSITS) Home/collateral visits _____
6)C. (OFC VSITS) Office visits _____

7) (APS PRIOR 817) Protective Services were needed and provided prior to completion of the initial assessment (Form 817 or 2638)?

Y. Yes N. No, or abbreviated document used

8) (MULTI REFRLS) Case while open this time had multiple referrals requiring additional investigation: (Circle one)

A. No
B. Yes, 1 additional referral
C. Yes, 2 or more additional referrals

IF INVALID, DO NOT COMPLETE FORM BEYOND THIS LINE

9) (VAL, RFSED) Protective Services were refused

Y. Yes, some or all refused N. No, none refused

10) (UNABL PROTCT SLF) In cases needing protective services the adult was unable to protect himself/ herself based on: (Circle one)

A. Physical and mental dysfunctioning
B. Mental dysfunctioning
C. Physical dysfunctioning

11) (PERP) Perpetrator was (Circle up to 3)

A. Self-neglect, no perpetrator
B. Spouse
C. Son
D. Daughter
E. Parent
F. Grandchild(ren)
G. Brother/sister-in-law
H. Niece/nephew
I. Brother/sister
J. Friend/neighbor
K. Facility/institution staff
L. Service provider
M. Uknown
N. Other

12) (SERV NEEDS) In cases needing protective services, the the need was for: (Circle up to 5 most significant)

A. Counseling
B. In-home Services (homemaker, meals, etc.)
C. Boarding, group or foster home
D. Mental health evaluation, treatment or placement
E. Alternative/better housing
F. Hospitalization
G. Nursing Home Care
H. Transportation
I. Day care shelter or utilities
J. Guardian/conservator
K. Other

13) (INSTITNL PLCMNT) At closure client was in institutional placement: (Circle one)

A. No
B. Yes, care paid for by Medicaid/TNcare
C. Yes, care paid for by other source
D. Unknown

14) (INCOM SOURCE) Source of income: (Circle up to 4 that apply)

A. SSI
B. VA
C. Social Security
D. Employed or self-employed
E. Retirement
F. None
G. Other
H. Unknown

15) (DHS LEGAL ACTION) Legal Action initiated by DHS: (Circle one)

A. No
B. Yes, court order was granted
C. Yes, court order was **not** granted

16) (CRT ORDR) If yes, and a court order was granted, indicate type of order: (Up to 6 most appropriate)

A. Consent to medical placement
B. Consent to non-medical placement
C. Consent to medical care
D. consent to surgery
E. Provide services
F. Search warrant
G. Injunction
H. Commitment
I. Temporary guardian/ conservator appointed
J. Probable cause examination only
K. Other

17) (OTHR LEGL ACTN) Legal action initiated by other person or agency, **not** DHS: (Circle one)

A. Not applicable
B. Conservatorship
C. Commitment
D. APS petition by private non-profit agency
E. Other

18) (PRIM PRBLM) The primary problem which existed in the case was caused by or greatly effected by: (Circle up to 4 most significant)

A. Illegal drug use
B. Social Isolation
C. Alcoholism
D. Poor health
E. Mental retardation
F. Mental Illness
G. Unemployment
H. Misuse of prescribed medication
I. Lack of transportation for needed social services
J. Lack of transportation for essential needs (food, utilities, medication, etc.)
K. Lack of money for food, shelter or utilities
L. Other

19) Number of perpetrators: (Write in)

19)A. **(NUM MALE PERPS)** Number of male perpetrators _____
19)B. **(NUM FEMALE PEPRS)** Number of female perpetrators _____

20) (PERP CONDITION) Condition of perpetrators: (Circle up to 8 that apply)

A. Alcoholic
B. Drug addict
C. Mental retardation
D. Mental illness
E. Unemployed
F. Immature/emotionally dependent
G. Stressed caregiver
H. Lack of adequate information
I. Lack of adequate skills
J. Financial dependence
K. Unknown
L. Other

21) (TYP ABUS) Case was (Circle up to 6 that apply)

A. Self-neglect
B. Neglect by others
C. Physical abuse
D. Sexual abuse
E. Emotional abuse
F. Financial exploitation
G. Other

FORM 1169 ADULT PROTECTIVE SERVICES
CLOSED CASES INPUT FORM

GENERAL INSTRUCTIONS

Purpose

The Closed Cases Input Form collects data that may be available only at the conclusion of the case, when all information regarding needs, service provision and outcomes is available. This is a primary source of specific program data used in program planning, training, justification and public education.

The closed case input form is required to be completed on every case at closure and a print screen showing the data on the HS-1169 is required in every closed case file. The form is legal-page size (8½ x 14 inches) and is available from Central Stores, order # 395-51-00HS1169, as a two-sheet—original and copy—NCR (Non Carbon Reproduction) document.

SPECIFIC INSTRUCTIONS:

All questions are answered based on the **most recent time the case was open**. If it has been opened and closed multiple times, **consider the last open and closure period**.

Heading:

- Enter the 11 digit computer-assigned case number with no spaces or hyphens between numbers.
- Enter the last name, first name and middle initial in the appropriate spaces of the person who has been designated as **Head of Case**.

1. Circle the type which best describes the person who made the referral that opened the case.

2. Circle the response priority/condition which best describes the referral that opened the case. If applicable you may use up to three (3) responses.

3. Circle the most accurate response time. The response time is the amount of time between the **referral being received by the Department** and the **investigating counselor initiating the investigation**. To accurately capture this data, it is essential to look at the date the referral was received, which may be different from the date the referral was assigned for investigation.

4. Circle where the adult client was living when the case was opened. Choose the first accurate answer. If the client was in a nursing home, the answer would be “D” and **not** “G”. Although each answer is technically correct “D” is the best answer.

5. This question wants to know whether or not the case required work beyond your normal working hours. This applies **anytime** between the case being opened and the time of closure.

6. Write in the number of contacts made in the case during the **first 60 days** after **the case was assigned**—phone calls, home/collateral visits, office visits.

7. Indicate whether or not the case required Protective Services prior to the Assessment (Form 817 or 2638) being completed. This would apply when a client is in a crisis and immediate assistance/protection is needed before the investigation and assessment have been completed. This type of intervention is stated on the Assessment, page 1.

8. After the case was opened the last time additional referrals were received while the case was active. The additional referrals required additional investigation.

   Continue only for those cases which were classified as "Valid". Valid cases are those in which the adult was in danger, at serious risk of harm and was in need of protection; or was in danger when the incident occurred and required action to prevent harm. Abuse, neglect, self-neglect, or exploitation did occur or was imminent. This includes those cases in which the adult needed help before the assessment was completed. If risk was eliminated prior to completion of the assessment, this was still a valid case.

9. Indicate whether the adult refused some or all needed risk-reduction services ("Y") or accepted all risk reduction services ("No", none refused). A Yes answer includes both
   - those cases in which the client refused DHS involvement or all services offered by APS, despite reasonable attempts to engage the client to accept at least some services, and the case was closed due to the client's refusal of services, **and**
   - those cases in which the client refused some services, but allowed other risk reduction services to be provided and/or further APS involvement, and the case may have remained open for provision of those services.

10. Self-explanatory.

11. The answer is based on the perpetrators who were identified in this case.

12. During the investigation it was determined that services were needed to protect the adult client. Circle the services, up to 5, which are most needed by this client (whether or not available or accepted).

13. Show whether, when the case was closed, the client was living in an institutional placement which includes nursing homes, state institutions, residential or group homes. If the answer is yes, **then indicate whether or not Medicaid is paying for the care which is provided in the facility**. "D. Unknown" applies to those cases in which the client **was** in an institutional placement when the case was closed, but the payment source is unknown **and** to those cases in which it is not known whether the client is in an institutional placement, such as a client with whom contact has been lost and who cannot be located.

14. Circle the primary sources of the client's income (up to four (4) sources).

15. Self-explanatory.

16. Self-explanatory.

17. Self-explanatory.

18. Circle the most significant problems which contributed to the abuse, neglect or exploitation (A/N/E) or the threats of A/N/E (up to four [4] responses).

19. Self-explanatory

20. Circle any (up to 8) of these conditions which describe any of the identified perpetrators in the case. **Self-neglect cases are, of course, excluded from this question.**

21. Circle up to 6 of the case types which apply to the case since it was last opened, based on the investigative findings.

VOLUNTEER ENROLLMENT FORM

(Name) Last First Middle Initial Date

(Home) Address City State Zip

(Business) Address City State Zip

Social Security No. _____ Date of Birth: _____

Valid Driver's License No. _____

Home Phone No. _____ Business Phone No. _____

Person to Notify in Case of Illness/ Accident

Name _____ Phone Number _____

Address _____

Special Instructions _____

Day(s) Available (circle) Mon. Tues. Wed. Thur. Fri. Sat. Sun.

Night(s) Available (circle) Mon. Tues. Wed. Thur. Fri. Sat. Sun.

Hobbies, Interests, Special Skills _____

Reason for Application to Volunteer Program (Describe) _____

Job Preference: (List in order of Interest)

1. _____
2. _____
3. _____

Previous Volunteer Work (Describe) _____

Married	_____	Widowed	_____	DHS Employee	_____	Male	_____
Single	_____	Student	_____	Retired	_____	Female	_____

Personal References:

1. _____ Phone No. _____
2. _____ Phone No. _____
3. _____ Phone No. _____

I understand as a volunteer with the Tennessee Department of Human Services that, in accordance with the law, I am considered to be a state employee for purposes of liability protection under State law for acts or omissions within the scope of the duties assigned to me by the Department. I understand that such protection does not exist for acts or omissions arising from my willful, malicious or criminal conduct or for acts or omissions done by me for personal gain.

I further understand that I am not eligible for workmen's compensation or other benefits offered to state employees.

As a volunteer with the Tennessee Department of Human Services I understand that divulging confidential information held by the Tennessee Department of Human Services to unauthorized persons is prohibited by law.

Parent or Guardian (if volunteer is under 18)	Signed
Date	Volunteer Coordinator

REGISTRATION OF VOLUNTEERS
TENNESSEE DEPARTMENT OF HUMAN SERVICES

Please Print Clearly

Individual's Name _____
(Last) (First) (Middle)

Address _____
(Number and Street) (City and State) (Zip Code)

Social Security Number _____

Region _____ **County of Residence** _____

Place a check to identify area(s) of previous volunteer service

COMMITTEES		**OTHER**	
Child Abuse Review Team	_____	Companionship	_____
Foster Care Review Board	_____	Office Assistance	_____
Social Services Advisory Council	_____	Transportation	_____
Volunteer Committee	_____	Other _____	
Other _____			

Mail To:

Volunteer Registration
c/o DHS Personnel
Citizens Plaza Building, 3rd Floor
400 Deaderick Street
Nashville, TN 37248

Tennessee Department of Human Services

EMERGENCY INFORMATION ABOUT ADULT IN FAMILY HOME CARE

Full Name _____ Date of Birth _____

Social Security # _____ TennCare # _____

RR Retirement # _____ Medicaid/Medicare # _____

*List Doctor(s), Clinic(s) or Hospital(s), include address and telephone numbers.

_____

_____

Preferred Hospital: _____

Adult is under treatment for (include doctor/clinic):

_____

_____

Doctor's instructions regarding medication are attached. NA ☐ Yes ☐ No ☐

Doctor's instructions regarding diet are attached. NA ☐ Yes ☐ No ☐

Doctor's instructions regarding day-to-day health routine are attached. NA ☐ Yes ☐ No ☐

Next appointment (specify doctor/clinic/location/date/time):

_____

List your nearest living relative:

Name _____ Relationship _____

Address _____ Phone # _____ Work # _____

Emergency Contact (Relative or friend who can be called in the event of emergency.):

Name _____ Relationship _____

Address _____ Phone # _____ Work # _____

Power of Attorney or Guardian: _____

Type of Will: _____

Location of insurance policies: _____

Ins. Co. _____ Policy # _____ Type & Amt. _____

Ins. Co. _____ Policy # _____ Type & Amt. _____

*Burial arrangements made? Yes ☐ No ☐

If yes, specify arrangements.

_____

_____

Counselor: _____ Work #: _____

Supervisor: _____ Work #: _____

I have been advised of my rights and have given DHS permission to maintain this information in my file for my benefit.

Client's Signature: _____ Date: _____

TENNESSEE DEPARTMENT OF HUMAN SERVICES
FIRE SAFETY CHECKLIST FOR FAMILY HOMES FOR ADULTS
(Three or fewer residents)

Name _____

Address _____

City _____ County _____

Zip Code _____ Telephone _____

Yes	No	N/A		
_____	_____		1.	The home has at least (2) remotely located outside exits which are easily opened from inside; and the passageways to these exits are free of obstructions.
_____	_____		2.	There is a window in each bedroom which will openly freely for an emergency exit providing a clear opening not less than 20 inches in width; 24 inches in height; and not more than 44 inches from the floor.
_____	_____		3.	The home has an approved A-B-C- fire extinguisher with needles and gauges. The exterminator must be easily accessible, in working order and *fully charged*. There should be an extinguisher on each level/floor of the home.
_____	_____		4.	There are smoke detectors in at least the following areas: each bedroom occupied by a resident, corridor(s), kitchen and any hazardous area. **Note: In a**ll newly constructed homes smoke detectors must be connected to the electrical system with battery back up operating at all times. UL approved battery powered smoke detectors are acceptable.
_____	_____		5.	The home is free of clutter, discarded or broken items.
_____	_____		6.	The home is free of all unvented fuel burning heaters.
_____	_____		7.	All bedrooms are without space heaters and when they are used in other rooms they have at least three (3) feet clearance on all sides.
_____	_____		8.	Combustible materials, gasoline or flammable liquids (paint, thinner, oil, other chemicals, etc.) are properly stored according to the manufacturer's directions, on the outside of the home.
_____	_____		9.	The residents are informed of the evacuation plan, which is sketched onto a layout of the home; the sketch is posted on the back of each door in each bedroom occupied by a resident.
_____	_____		10.	Visual inspection reveals the absence of electrical hazards such as: overloaded electrical panel/master function box; extension cords under rugs; carpets or heavy objects/furniture where they may be stepped on or tripped over; frayed wiring; or multiple plug adapter(s).
_____	_____		11.	The home is inspected by a licensed electrician at the time of the initial home study, and thereafter as Indicated by the electrician. All fire safety deficiencies identified by the electrician are corrected prior to approval of the home to provide family home care. A record of any inspection is maintained in the family home case file.
_____	_____		12.	Interior doors are at least 28 inches wide (bathroom doors may be 24 inches wide).
_____	_____	_____	13.	Interior doors, in family homes to be occupied by adults in wheel chairs, are at least 32 inches wide.
_____	_____	_____	14.	All fireplaces have a protective screen which is secured in place.
_____	_____	_____	15.	Fireplaces used as a primary source of heat are inspected annually by a chimney sweep and those used only occasionally are inspected at least biennially; or, as indicated by the chimney sweep. Documentation of the inspection(s) is maintained.
_____	_____	_____	16.	Ramps with no more than one (1) inch fall; one (1) inch to ten (10)inches, are provided in any family home to be occupied by residents who must use a wheelchair. The ramp must be wide enough to accommodate a wheelchair.
_____	_____	_____	17.	Upstairs bedrooms occupied by family home residents have access to outside exits on the upstairs level (metal stairs or wood treated stairs with an awning or covering of fiberglass, wood, etc.).
_____	_____	_____	18.	Mobile/modular homes must meet the following conditions: was built since 1974; is 24 feet wide (double wide); has front and rear exits; and is anchored (tied down) with wheels removed.
_____	_____	_____	19.	There are designated smoking areas with non combustible ashtrays provided wherever smoking is permitted.
_____	_____	_____	20.	The home has unannounced fire drills (at least monthly) and a record of the fire drills is maintained.

_____ _____
Date(s) Inspected (Name and Title of person who completed checklist)

Statements 1 through 9 are requirements; however in some instances 13 through 18 may not apply and would be checked "N/A (not applicable). Statement 20 is recommended but not required.

TENNESSEE DEPARTMENT OF HUMAN SERVICES - ADULT PROTECTIVE SERVICES

PHYSICIAN'S STATEMENT OF NEED FOR COURT ORDERED PROTECTIVE SERVICES

Adult Protection Act T.C.A. 71-6-101 et seq.

PURPOSE: Several legal options are available to the Tennessee Department of Human Services (DHS) in providing protective services. The most frequently requested type of court order is for custody to consent to treatment or placement of an adult. In order for DHS to obtain such an order, the adult must lack the **"capacity to consent"** to protective services. In addition to this requirement, the adult must be in **"imminent danger"** if he/she does not receive the recommended services (including care, treatment, or placement). Other types of orders may also be possible and considered based on the information provided.

The information provided in numbers 1- 6 will be used in deciding whether or not legal intervention is necessary or possible. It may, also, be used to decide the need for other types of Protective Services.

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

DATE OF ADMISSION: _____ **DATE LAST SEEN:** _____

DIAGNOSIS:

_____

_____

_____

_____

_____

_____

1. The above patient is presently being treated by me at _____

_____

2. **Capacity to Consent** to Protective Services including exams, treatment, or placement:

The legal standard for capacity under the Adult Protection Act means that the person must have the mental ability to make a rational decision (the ability to perceive and appreciate all relevant facts to reach a rational judgement based upon such facts). A decision itself to refuse services cannot be the sole evidence for finding the person lacking capacity to consent. If the patient gives evidence of comprehension of the facts of his/her condition and expresses his/her unequivocal desire to refuse services in view of these comprehended facts, then the patient's decision, however unreasonable to others, must be accepted. Consider whether or not he/she understands the consequences of the decision. Additionally, the law recognizes "partial insanity" (partial incompetence, blocking): therefore, a person may have capacity in some matters and may lack capacity in others.

The above patient **lacks capacity to consent** to decisions concerning his/her care, as evidenced by the following facts:

_____

_____

_____

_____

_____

ADULT PROTECTIVE SERVICES - PHYSICIAN'S STATEMENT

Patient's Name _____

3. <u>Imminent Danger of Irreparable Physical or Mental Harm or Death:</u>

The legal standard for **imminent danger** means conditions calculated to and capable of producing within a relatively short period of time, a reasonably strong probability of resultant irreparable physical or mental harm or the cessation of life, if such conditions are not removed or alleviated.

This patient is in **imminent danger** for the following reason(s):

_____

_____

_____

_____

and requires the following treatment and/or care:

_____

_____

_____

4. He/she is in need of the following services (Example - nursing home, medical follow-up, etc.):

_____

_____

_____

5. The prognosis for this patient **without** treatment is: (include time frames)

_____

_____

_____

6. The prognosis for this patient **with** the recommended treatment is: (include time frames)

_____

_____

_____

7. Comments:

_____

_____

_____

8. Print your name and specialty, if any: _____

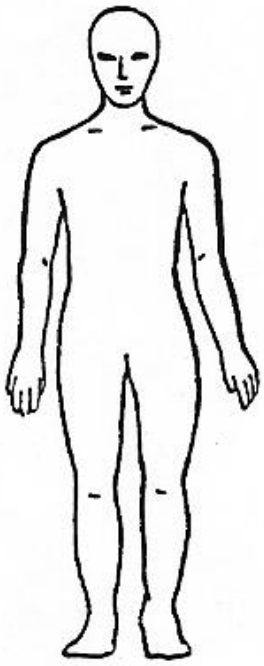
Signed: _____ Date: _____

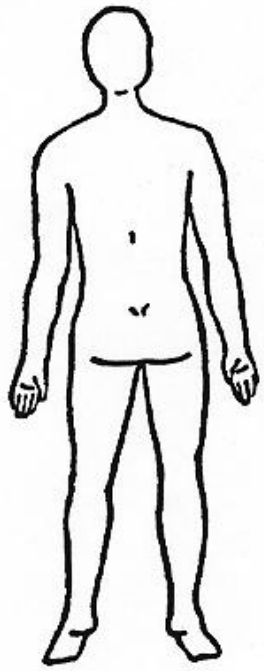
Check if additional information is attached. ☐

BODY DIAGRAM CHART

Indicate location of all visible injuries or medical conditions. Include the description, color, and size of each.

Client's Name _____





Name of Person Completing Form _____ Date _____

Form HS 2621 Adult Protective Services
Body Diagram Chart

Instructions

Complete and attach the body diagram chart when there are visible signs of illness or injury which need to be documented. When the adult is suffering from lacerations, bruises, bedsores, etc., the chart is to be used to indicate the location, size and description of the injury/condition. **Injuries which are not present when the assessment is completed but were present during the investigation should be documented on the body chart.** The body chart diagram may be used in conjunction with a formal medical report or when there is no formal medical report available.

The Body Diagram Chart is available from Central Stores, order # 395-51-HS2621.

Tennessee Department of Human Services
Adult Protective Services

ABBREVIATED DOCUMENTATION OF APS INVESTIGATION/ASSESSMENT

CLIENT'S NAME **COUNTY**

REFERRAL DATE **COUNSELOR**

ABBREVIATED DOCUMENTATION OF THE APS INVESTIGATION/ASSESSMENT WAS COMPLETED ON THIS CASE FOR THE FOLLOWING REASONS: (CHECK ALL THAT APPLY)

☐ The allegations regarding the threat of harm are **CLEARLY WITHOUT SUBSTANCE**(The APS counselor observes the home and/or living arrangement and speaks to the adult and others who have knowledge of the situation and there is no information to support the allegations.)

☐ When the investigation was initiated, the APS Counselor found the adult had already been placed in a long-term protective environment and was no longer at risk for the allegations as reported.

☐ There are verifiable plans for the adult to be placed in a protective environment in the immediate future and an appropriate intermediary plan is established in the interim period

☐ When the investigation was initiated, the allegations reported, although accurate, had already been addressed and resolved.

☐ At the time of the investigation if is verified that the alleged perpetrator no longer has access to the reported victim or other vulnerable adults and no other risk factors are identified.

☐ Unable to locate following diligent efforts.

☐ During the course of the investigation and prior to the completion of the assessment, the alleged victim died and the counselor was able to verify that the death is the result of natural causes, unrelated to any abuse, neglect or exploitation.

☐ Following the investigation of the allegations, the client appeared to understand the consequences of his/her actions/decisions and refused services.

THE FOLLOWING ACTIVITIES WERE COMPLETED: (CHECK ALL COMPLETED ACTIVITIES)

☐ Adult interviewed and observed. APS counselor must see and speak to the adult about the allegations Date:

☐ Appropriate caretaker interviewed regarding the allegations (the adult was unable to communicate or was incapacitated).

☐ Home visit made to place of residence if the allegations pertain to hazardous home conditions or other issues relevant to the physical living space.

☐ Other persons or professionals having knowledge of the situation contacted (there is reason to believe they can contribute relevant information.) Date:

☐ 1215 sent to appropriate agencies (required on all referrals alleging abuse, neglect and/or exploitation)

☐ Reporter contacted to clarify allegations (when appear to be without substance).

☐ Reporter contacted regarding the action taken (Required) Date:

☐ Supervisor contacted regarding use of Form HS-2630 Date:

Client Name:

ABBREVIATED DOCUMENTATION OF APS INVESTIGATION/ASSESSMENT

SUMMARY OF CONTACTS AND DATES:

OUTCOME OF CASE ACTIVITY AND RISK REDUCTION:

☐ **VALID**

- ☐ Case Indicated/No Perpetrator (Self-Neglect)
- ☐ Case Indicated/Perpetrator Indicated
- ☐ Case Indicated/Perpetrator Unknown
- ☐ Case Indicated/Alleged Perpetrator-Not able to Determine
- ☐ Case Indicated/Perpetrator Unfounded
- ☐ Case Indicated/Threat of Danger

☐ **INVALID**

- ☐ Invalid Case/Case Unfounded
- ☐ Investigation not completed

Reason:

Counselor's Name: Date:

Supervisor's Name: Date:

FORM HS2630

ABBREVIATED DOCUMENTATION OF APS INVESTIGATION/ASSESSMENT

INSTRUCTIONS

Purpose

This form is intended to provide an abbreviated documentation option when full documentation is unnecessary. The specific case situations are listed on the form and discussed in **Section 4-16**. It is **not** intended to be used in all invalid cases. Most cases will require a full investigation/assessment in order to determine case validity and will require completion of the Case Assessment Form 2861 to provide adequate documentation of the investigation/assessment.

The HS-2630 is available as an electronic form on the DHS Intranet.

Initiation of the Form

Use of the Form HS-2630 is to be approved by the APS supervisor and completed ***within 30 calendar days*** from the date of assignment

ABBREVIATED DOCUMENTATION OF APS INVESTIGATION/ ASSESSMENT

Some case situations do not require completion of all elements of the assessment, as structured on the Case Assessment (HS-2861). Therefore, abbreviated documentation of the APS investigation/assessment may be completed for the following reasons.

1. The allegations regarding the threat of harm are ***CLEARLY ENTIRELY*** WITHOUT SUBSTANCE:

   - On initial contact with the client it is observed that the client's circumstances or the environmental factors are clearly different from those alleged, <u>and</u> there are no other indicators that suggest there may be a need for protective services.

     Example: 1.) Allegations of injury due to abuse. There are <u>no injuries whatsoever</u>, and investigation is not needed to determine the cause of any injuries.

     Example: 2.) Allegations that living conditions are a source of risk. The home is in good condition, and living conditions are readily observed to be appropriate for the adult and without any hazards.

     This gives reason to believe the allegations have no substance and are based on misinformation.

- Others who have knowledge of the situation and are credible support that the allegations are obviously without substance and there are no other conditions that create risk of harm.
-
- There is no information to support the allegations **or other conditions of risk**.

  This application does **not** apply to those cases which require a full investigation to determine that the case is not valid, **regardless** of the time frame in which the investigation can be conducted.

  Some allegations are unlikely to ever be resolved without a full investigation, because their lack of substance and the need for protective services is not immediately apparent on the surface (such as sexual abuse, financial exploitation, etc.).

  Cases in which **any** part of the allegations need investigation to determine their validity are **not** appropriate for the Abbreviated Documentation form.

2. When the investigation is initiated, the APS Counselor finds that, without APS intervention, the adult has already been placed in a long-term protective environment and is no longer at risk for the allegations as reported.

3. There are verifiable plans for the adult, without APS intervention, to be placed in a protective environment in the immediate future and an appropriate intermediary plan was established in the interim.

4. When the investigation was initiated, the allegations reported, although accurate, had already been addressed and resolved without APS intervention.

5 When the investigation was initiated, it was verified that, without APS intervention, the alleged perpetrator no longer had access to the reported victim or other vulnerable adults and no other risk factors were identified.

6. APS is unable to locate the client following diligent efforts.

7. During the course of the investigation and prior to the completion of the assessment, the alleged victim dies and the counselor is able to verify that the death is the result of natural causes, unrelated to any abuse, neglect or exploitation.

8. Following the investigation, the client appears to understand the consequences of his/her actions/decisions and refused services.

Required Activities:

The following activities constitute an abbreviated investigation and assessment of a report. **All** of these activities must be completed in order to use the abbreviated documentation form. (Numbers 6 and 7 above are exceptions.)

A. Adult interviewed and observed. APS counselor must actually see and speak to the adult about the allegations.

B. If the adult is unable to communicate or is incapacitated, reputable persons having knowledge of the situation will be interviewed regarding the allegations.

C. Home visit is needed if the allegations pertain to hazardous home conditions or other issues relevant to the physical living space.

D. Other persons or professionals having knowledge of the situation must be contacted if there is a reason to believe they can contribute relevant information.

E. As with all other APS referrals:
   1.) the HS-0875 (1215) must be sent, and
   2.) the reporter must be contacted regarding the action taken, **and** to clarify the allegations when the allegations appeared on initiation of the investigation to have been clearly without substance.

If a case is identified by the investigating counselor as fitting one of the case situations in numbers 1 through 7, then they may request approval from their supervisor to use the abbreviated documentation form. **The form must be completed and all required activities must be completed and approved by the field supervisor within thirty (30) calendar days from the date of assignment.**

DOCUMENTATION

These case files will contain the following documentation:

- FORM HS-0055 (700), APS INTAKE REFERRAL FORM
- ACSS CASE INFORMATION print screen
- ACSS INDIVIDUAL CLOSURE DATA print screen
- ACSS CLOSED CASE QUESTIONNAIRE CLOSURE DATA print screen
- ABBREVIATED DOCUMENTATION OF APS INVESTIGATION/ASSESSMENT, FORM HS-2630

Abbreviated documentation cannot be used for investigations in facilities or institutions unless specified in **Section 7** and in compliance with any existing Memoranda of Understanding.

File

The completed Form HS-2630 should be filed on the left side of the case file.

Signatures

Counselor and Supervisor signatures are required.

This form is available on the Department of Human Services Intranet.

(FACILITY) ADULT PROTECTIVE SERVICES INVESTIGATIVE REPORT/ASSESSMENT

Client Name Age DOB / / SS# - -

Location

Type of Referral ☐ Physical Abuse ☐ Sex Abuse ☐ Self-Neglect

☐ Emotional Abuse ☐ Neglect ☐ Financial Exploitation

Specific allegations stated in the referral:

Date of Referral(s) / / 1st Face-to-Face Contact with Client(s) / /

Date of Initiation of Investigation / / Type of Contact

FACILITY INFORMATION:

Name Type

Facility Administrator's Name and Title

Licensed by Certified by

1215 Sent to:	Date	This Agency Investigated		Independently		Jointly with APS	
		Yes	No	Yes	No	Yes	No
☐ TN Dept. of Health	/ /	☐	☐	☐	☐	☐	☐
☐ Law Enforcement	/ /	☐	☐	☐	☐	☐	☐
☐ TN Dept. of Mental Health	/ /	☐	☐	☐	☐	☐	☐
☐ TN Dept. of Developmental Disabilities	/ /	☐	☐	☐	☐	☐	☐
☐ TBI	/ /	☐	☐	☐	☐	☐	☐
☐ Other: Explain							

Documents Reviewed: (Check and date all that apply)

	Date		Date
☐ Physician Progress Notes	/ /	☐ Physician Orders	/ /
☐ Physician Telephone Orders	/ /	☐ Hospital Transfer Orders	/ /
☐ Blood Chemistry Reports	/ /	☐ Special Labs	/ /
☐ Patient Weight Record	/ /	☐ Nurse Notes	/ /
☐ Monthly Nursing Assessments	/ /	☐ Social Work Assessment and Progress Record	/ /
☐ Victim Incident Reports	/ /	☐ Pertinent Training Materials	/ /
☐ Plan of Care	/ /	☐ Work Schedules	/ /
☐ Other: Explain		☐ Other: Explain	

☐ Photos Taken Date: / / Included in File: Yes ☐ No ☐ If No, where:

Client Name:

Assistance Requested from:	**Name**	**Date**	**Assisted with Investigation**	
			Yes	**No**
Ombudsman		/ /	☐	☐
Patient Care Advocate		/ /	☐	☐
Family Member(s)		/ /	☐	☐
Other(s)		/ /	☐	☐

Action taken by facility prior to initiation of APS investigation:

SECTION 1. IMMEDIATE NEEDS/SERVICES IDENTIFIED BY APS AND PROVIDED PRIOR TO COMPLETING ASSESSEMENT

Immediate Needs/Risks Identified:	**Immediate Services Provided:**
a.	a.
b.	b.
c.	c.

SECTION 2. CLIENT'S PHYSICAL AND MENTAL HEALTH

A. Client's Physicians/Hospitals:

	Name	Date(s) Records: Requested	Obtained
1.		/ /	/ /
2.		/ /	/ /
3.		/ /	/ /
4.		/ /	/ /

B. Client's Medications: (Attach list of current meds from facility chart.) ☐ **Date: / /**

C. Physical and/or Mental Health Problems or Conditions:

	Treated		Treated
1.	☐	2.	☐
3.	☐	4.	☐
5.	☐	6.	☐
7.	☐	8.	☐

D. Provide a description of the client's physical appearance and capabilities:

E. Describe client's communication skills:

If someone assisted with the interview, who assisted?

Name: Relationship:

Client Name:

F. Activities of Daily Living (ADL) – for each activity, indicate functional level of client:

Client can do:

Activities	Ambulating	Bathing	Dressing	Meal Prep	Toileting	Feeding Self	Grocery Shopping	Paying Bills	Household Chores	Others: Explain
Independently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
With Assistance	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Not at All	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Against Medical Advice	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Refuses to Do	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

G. Physical/mental health risk factors present (a blank indicates you do not know the information):

Yes	No		Yes	No		Yes	No	
☐	☐	Client Malnourished	☐	☐	Overgrown Nails	☐	☐	Dental Problems
☐	☐	Client Dehydrated	☐	☐	Excess Dirt, Fleas	☐	☐	Mental Illness
☐	☐	Client Incontinent	☐	☐	Bedsores, Ulcers	☐	☐	Recent Decline Physically
☐	☐	Feces, Urine, Odor or Presence	☐	☐	Skin Rashes, Discoloration	☐	☐	Recent Decline Mentally
☐	☐	Client Flushed, Sweating, Shivering	☐	☐	Bedfast	☐	☐	Client Depressed
☐	☐	Client Unable to Sleep	☐	☐	Constant Confusion	☐	☐	Developmental Disability
☐	☐	Client Wandering	☐	☐	Client Forgetful			

H. In what way does the client's physical/mental condition endanger him/her ability to protect or provide for him/herself? Be specific.

Client Name:

SECTION 3. ABUSE and NEGLECT (Self-Neglecting cases require a Form 817.)

A. Summary of client's statement concerning needs, problems, wishes, concerns:

B. List any type of maltreatment identified during the investigation.

C. Description of Client's actual condition at time of injury/illness (attach Body Diagram or Medical Report (if applicable).

D. Client's reaction to Department of Human Services: ☐ Cooperative ☐ Resistant ☐ Uncooperative ☐ Mental/Physical ability will not permit a response

E. Abuse and neglect risk factors present: (A blank indicates you do not know the information.)

Yes	No		Yes	No		Yes	No	
☐	☐	Needed Assistance with ADLs Lacking	☐	☐	Old and New Bruises, Welts or Injuries	☐	☐	Client Combative, Hostile or Sexually Acting Out
☐	☐	Food/Medicine Inconsistent with Condition	☐	☐	Injuries to Head, Face, Genitals	☐	☐	Nightmares, Night Terrors, Sleep Disturbances
☐	☐	Client Needing Supervision being Left Alone	☐	☐	Immediate Hospitalization or Treatment Needed	☐	☐	Evidence of Sexually Transmitted Disease
☐	☐	Client Isolated from Family Emotionally or Physically	☐	☐	Prolonged Time Between Illness/Injuries and Medical Care	☐	☐	Genital or Urinary Tract Irritation, Infection or Scarring
☐	☐	Alleged Perpetrator will not Allow Privacy for Interview	☐	☐	Explanation Inconsistent with Injury	☐	☐	Improper Restraint Used (Length of Time or Type of Restraint)
☐	☐	Client Looking to Perpetrator for Answers	☐	☐	Self-blaming, Low Self-esteem	☐	☐	Inadequate Sleeping Arrangements
☐	☐	Client Nonverbal	☐	☐	Client Fearful of Others		☐	Other

Client Name:

F. Client Previously Victimized:

☐ Not at all ☐ One time ☐ Several times over a short period of time
☐ Many times over a long period of time ☐ Unknown ☐ Other

G. Previous Victimization:

☐ Same perpetrator ☐ Different perpetrator ☐ Unknown perpetrator ☐ N/A

H. Current alleged perpetrator's name:

Relationship:

I. Perpetrator contact with client: ☐ Daily ☐ Weekly ☐ Other

Shift worked: Days Worked:

J. Perpetrator reaction to Department of Human Services: ☐ Cooperative ☐ Uncooperative
☐ Refused to be interviewed ☐ Interviewed with legal counsel

K. Perpetrator response to allegations: ☐ Admits ☐ Denies

L. ☐ Police records checked: Date: / / ☐ Abuse Registry checked: Date: / /

Relevant information obtained:

M. Summary of perpetrator's statement concerning abuse, neglect, needed assistance, etc:

☐ No contact made and reason:

N. COMMON WARNING SIGNALS PRESENT

Presence of these "red flags" indicates a high risk for abuse/neglect and requires careful evaluation.

Yes	No	**CLIENT INDICATORS**	Yes	No	**CAREGIVER INDICATORS**
☐	☐	Alcohol/Drug Misuse	☐	☐	Alcohol/Drug Misuse
☐	☐	Self-Blaming	☐	☐	Inexperienced/Poorly Trained
☐	☐	Excessive Loyalty	☐	☐	Blaming Client/Hypercritical
☐	☐	Stoicism (No Emotions)	☐	☐	Private Gifts to Client
☐	☐	Provocative Behavior	☐	☐	Favoritism Toward Client
☐	☐	Self-Abusive Behavior	☐	☐	Reluctant to Provide Care
☐	☐	Fearful of Caregiver/Others	☐	☐	Overeager to Provide Care
			☐	☐	Works Excessive Hours

FAMILY SYSTEMS INDICATORS

Yes	No		Yes	No	
☐	☐	Lack of Family Support	☐	☐	Economic/Financial Problems
☐	☐	Disagreement between Family and Facility	☐	☐	Fearful of Facility's Retribution

Client Name:

SECTION 4. FINANCIAL RESOURCES AND EXPLOITATION

(Optional, except when there are concerns regarding resources or financial exploitation)

A. Financial resources available: Income Amt./Source Food Stamps

TennCare Medicare Other Assistance or Resources Private Insurance

B. Facility expenses: Patient liability Patient Trust TennCare/Medicare liability

Expenditures from Trust to facility Balance of Trust Miscellaneous fees

C. Individual responsible for managing resources: Name

Position/Title Phone

Address:

☐ Client ☐ Spouse ☐ Relative ☐ Friend ☐ Other

D. Financial risk factors present: (A blank indicates you do not know the information.)

Yes	No		Yes	No		Yes	No	
☐	☐	Bills Unpaid	☐	☐	Client's Money Being Taken	☐	☐	Client Giving Money Away
☐	☐	Checks Uncashed	☐	☐	Client Unaware of Finances	☐	☐	Money Lost or Misplaced
☐	☐	Money Gone Before Month's End	☐	☐	Caregiver Misusing Client's Money	☐	☐	Client Partially/Totally Financially Dependent on Others
☐	☐	Assets Inconsistent with Standard of Living	☐	☐	Inadequate Funds for Expenses	☐	☐	Depleted Funds, Questionable Reason

☐ Other:

E. How does the client's financial situation impact his/her condition?

SECTION 5. ENVIRONMENTAL CONDITIONS

Are there health or safety hazards which adversely affect the client as a result of living in this facility?

Yes ☐ No ☐

If yes, state the conditions, the date and method of reporting to the licensing agency:

Client Name:

SECTION 6. LEGAL INFORMATION

Please provide the following information regarding legal status of client.

Yes	No		Yes	No	
☐	☐	Client has a durable power of attorney for health care	☐	☐	Client has a conservator of person only
☐	☐	Client has a durable power of attorney for finances	☐	☐	Client has a conservator of person & property
☐	☐	Client is in DHS custody or other APS court order	☐	☐	Client has a conservator of property only
☐	☐	Client has been legally adjudicated incompetent			
☐	☐	Injunctive relief has been sought by APS	Date:		
☐	☐	Injunction obtained	Date:		

A. If yes to any of the above, please provide the following information.

Name:

Address:

Phone Number:

Location of document:

Court of jurisdiction:

County of jurisdiction:

B. Specify any risk pertaining to client (Related to A.)

SECTION 7. SUPPORT SYSTEM

A. Explain whether or not the client has a support system outside the facility. Who makes up the support system? What impact does the support system have on the client's care and safety?

Client Name:

SECTION 8. SUMMARY: Considering all risk factors and all categories of information, determine the overall level of risk and provide supporting documentation of classification.

CASE TYPE: ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Neglect ☐ Financial Exploitation

OVERALL LEVEL OF RISK: ☐ No Risk ☐ Low ☐ Intermediate ☐ High

CASE CLASSIFICATION: Assign the appropriate classification type.

☐ **VALID**

- ☐ Case Indicated/No Perpetrator (Self-Neglect)
- ☐ Case Indicated/ Perpetrator Indicated
- ☐ Case Indicated/Perpetrator Unknown
- ☐ Case Indicated/Alleged Perpetrator – Not Able to Determine
- ☐ Case Indicated/Perpetrator Unfounded
- ☐ Case Indicated/Threat of Danger

☐ **INVALID** Invalid Case/Case Unfounded

SECTION 9

Recommendations and Actions Planned

Counselor's Name: Date:

Supervisor's Name: Date:

Client Name:

SECTION 10. ADDITIONAL INFORMATION

A. Report was made at the conclusion of the investigation to the person who made the referral to us:

☐ **Yes, give date:** ☐ **No, explain:**

B. Final Investigative Reports were Requested from:

Agency	**Date Requested**	**Date Received**

C. Written Copy of APS Assessment, Report or Findings was Shared With: (as permitted by policy)

Agency	**Date**

SECTION 11 CASE CLOSURE

Case Closed: (Date) / /

Explanation:

LEVEL OF RISK AT CLOSURE: ☐ **No Risk** ☐ **Low** ☐ **Intermediate** ☐ **High**

☐ **Attachments**

Client Name:

SECTION 12. INTERVIEWS

A. Persons interviewed not included in B. (No relevant information was provided.)

Date	Type	Name	Relationship

B. Other persons interviewed who provided information used in the assessment:

Date	Type of Contact	Name	Relationship	Content of Interviews

FORM 2638 ADULT PROTECTIVE SERVICES INVESTIGATIVE REPORT/ASSESSMENT (FACILITY)

GENERAL INSTRUCTIONS

Purpose

The APS Investigative Report/Assessment is a post-investigative document, to assist counselors in documenting the investigation and assessing strengths, needs, and risks in adult protective service cases. This report/assessment will then serve as a basis for recommendations and actions to be taken in order to ensure the safety and care of APS clients who have been abused, neglected or exploited while in a facility.

The HS 2638 is available as an electronic form on the Department of Human Services intranet.

Initiation of the Form

The Investigative Report/Assessment, Form 2638, is to be completed **at the conclusion of the investigation, within 60 days or less of the assignment of the initial referral for investigation.**

Preparing for the Assessment

An accurate, thorough case assessment is dependent upon a thorough investigation being conducted, including face-to-face and other contacts with the client, facility staff, relatives, friends, physicians, other agencies or significant individuals, as appropriate. While counselor observation is crucial in investigation and assessment, the involvement of others with day-to-day knowledge or with expertise regarding the client's situation will provide information not readily visible to the counselor. Such information may either confirm or contradict initial counselor observations or client statements. **The completed investigative assessment should accurately reflect the circumstances which exist at the time it is written, once the investigation is complete, reflect changes that have occurred since initiation of the investigation and whether or not the allegations which were reported are valid.**

Conditions/Actions Prior to, During and After the Assessment

The counselor is responsible within the document to deal with three time frames:

1. **Past - Prior to Assessment**

   Occurrences or situations which have existed in the past should be addressed in three ways:

   a. Action taken by the facility **prior** to initiation of the APS investigation is identified on page 2.

b. Risks/dangers which were identified **prior** to the assessment being completed and which required intervention **before** the assessment was completed should be noted in Section 1, ***"Immediate Needs/Services Provided Prior to Completing Assessment"***. Space is provided for the counselor to list the risks/dangers identified and the assistance or services provided or obtained.

c. Completion of the Assessment (Form 2638) allows reduced dictation/case recording in cases in which only a few contacts are needed. However, the information obtained and used in decision-making must be clearly represented on the Form 2638. All contacts must be clearly documented.

2. **Present - Time of Assessment**

The current situation (that which exists for the client at the time of writing the assessment) should be reflected throughout the document and is the foundation for determining levels of risk and needed intervention, taking into consideration any recent changes which impact the client's health and/or safety.

3. **Future - Recommendations/Actions Planned**

Those things which are expected to occur and activities to be completed by the counselor, or others in addressing client needs/risks should be reflected in Section 9, Recommendations and Actions Planned.

Risk Factor Checklist, Conclusion and Assessment of Risk

Throughout the case assessment, the counselor is expected to look critically at the client's situation to determine what the client wants, to identify strengths, weaknesses, client needs and available resources to meet needs. In documenting the assessment, the counselor is to supply basic information relevant to six major areas of a client's life: client's physical/mental health; abuse, neglect and exploitation factors; financial resources; environmental conditions; legal status; and support systems.

Having provided basic information requested in each of these areas and documented the information obtained investigating the case, the counselor then determines the level of risk to the client. In determining and documenting the level of risk, counselors are provided with a list of risk factors for several areas. While the list of risk factors is not exhaustive, it contains many of the primary factors. When factors exist within a particular situation which are different from those factors in the lists provided, the counselor is to add these to the lists of risk factors.

In conjunction with the lists of risk factors found on the Form 2638, counselors should use the APS risk factor matrix. (See Appendix **Section 11-13**.)

Within each risk factor list, a check in the "Yes" box will indicate the factor is present, and a check in the "No" box will indicate the factor is not present. No check in either box indicates that information regarding that factor is unknown and the counselor should explain why the information is not available. Risk factors which are present but not listed should be documented in the "other" category. Each checklist is intended to guide a counselor in thinking through the process of assessment and in documenting the level of risk to the client and the validity of the allegations in the report.

Determining and Assigning Level of Risk

In determining the level of risk to a client the counselor must examine the information provided in each section of the assessment and consider the total circumstances in order to determine the **overall** level of risk.

Professional discretion is necessary on the part of the counselor in assigning the particular level of risk for a case overall. While there are no magical ways of "computing" or determining level of risk, using the ***Guidelines for Assessing Levels of Risk* (Appendix, Section 11-13)** which provides examples of each level of risk for each of the factors may be helpful. Look for similarities between the client's situation and the examples provided in the guidelines. In addition, the following broad guidelines should be used in assigning risk level:

Recognizing that risk is on a continuum and interventions are on a continuum many individualized factors will go into deciding the most appropriate level of each. Generally, if the level of risk falls between points on the continuum, treat it as being at the higher level of risk; for example, if a situation falls between Low and Intermediate levels of risk, treat it as a condition of Intermediate risk. The following questions may also assist in determining the most accurate risk rating of a client's current condition or situation.

- What will happen to the client if APS does not intervene?
- How urgent, complex and serious is the client's situation?

Once the relevant information is reviewed, the counselor will need to decide whether any of the following are present:

Risk or existence of physical or mental injury, serious illness, sexual abuse or risk of death.

The more immediate and severe the risk or presence of the above conditions, the higher the risk to the client. When the likelihood of such conditions is less immediate or serious then the risk to the client is lower.

Some examples of each level of risk follow:

High Risk - A client who is severely functionally limited, profoundly mentally retarded, nonverbal, or seriously mentally ill, unaware of their resources, totally dependent upon others financially, is living in an environment that is dangerously unsafe or in which the administrator or director of a facility does not act quickly and appropriately to protect the client, is left without a caregiver or proper supervision, or has a caregiver who does not provide critically needed care, will likely be in high risk in each of these areas. This situation will require that care or intervention be planned and acted upon quickly. Multiple services may be needed. Court action may be required, or continuous or frequent involvement by the counselor or others may be necessary to protect the client and/or meet basic needs.

Intermediate Risk - The client at intermediate risk may have more strengths within a given area than a high risk client. For example: The adult may be ill, mistreated or moderately limited, but be able to communicate in some manner, or have inadequate family support, but the type of maltreatment is less severe. A caregiver who needs to learn better methods may put the client at intermediate risk, as opposed to the absence of a caregiver or the presence of a caregiver who is blaming or resistant to caring for the client.

Low Risk - The problems encountered at this level are least likely to cause serious danger to the adult. The risk may be very limited. When the risk to the client is borderline there must be clear reasons to expect continued deterioration. A low risk case may be a client who is dependent on a caregiver who does not always respond to the client's needs promptly or appropriately, or a client who is verbal and seen regularly by family or who participates in activities outside the facility. A low risk case may need only limited contact, or retraining of the caregiver to reduce or eliminate the risk.

Areas of Client Strength should indicate specific areas of a client's life which pose no risk/danger to the client and which actually are strengths on which to build. For example, the client has adequate resources which are well managed and accounted for by the institution/facility, has the ability to communicate, or has family actively involved.

Overall Risks - The overall rating will take into account the risk of physical/mental injury or sexual abuse and the likelihood of serious illness or death of the adult if interventions/services are not provided.

Failure by the administrator or director of a facility to take action to protect the client will result in elevating the risk level and will require continued APS involvement until the client is adequately protected.

The counselor will determine the rating to assign, once the impact of each area is carefully weighed and the overall likelihood of the most serious consequences as listed above is determined. When assigning the overall rating it will be helpful to consider the immediacy, intensity and frequency of the services or interventions required by the client's situation. The final overall rating will be the indication of the level of need for attention and counselor involvement required by the case as a whole, as well as considerations of the case classification (See **Section 4 -13**).

SPECIFIC INSTRUCTIONS

Counselor should complete **identifying information** for client(s).

Indicate the **type of referral** by checking all the types which apply to the specific referral.

List all of the **specific allegations of abuse, neglect, exploitation** stated in the referral.

Referral date(s) include all referrals which were received and are addressed within the assessment.

First face-to-face contact with the client during the investigation, give the **date**.

Date the **investigation** was **initiated** and the **type of contact** (may differ from 1st face-to-face).

FACILITY INFORMATION

Name and type of facility/institution.

Name and title of the facility administrator.

Indicate **by whom the facility is licensed and/or certified.**

Form HS 0875 (1215)

Indicate by checking the appropriate box to what agency **Form 0875 (1215)** (Report of Alleged Abuse, Neglect, Exploitation of an Adult) **was sent**, the **date** it was sent, whether or not that **agency investigated the allegations**, and whether the **investigation was conducted independently** or the **investigation was conducted jointly with APS.**

DOCUMENTS

Check and date all **Documents Reviewed** in conjunction with the investigation. It will not be necessary to review all the documents listed during every investigation. Check only those that apply. If **photographs** were taken, indicate by checking the appropriate box, as well as **the date** they were taken, whether or not they are **in the file**, and **if not, who has the photos.**

ASSISTANCE REQUESTED

List the name of anyone from whom **Assistance was Requested** and give the **date** of the request. Indicate with a check mark anyone **who assisted with the investigation.**

Explain what, if any, **Action** was **taken by the facility** prior to the initiation of the APS investigation.

SECTION 1 Immediate Needs/Services Provided Prior to Completing Assessment

In the course of investigation and assessment, a client may be found to have needs which require immediate attention/intervention by the counselor or others. The needs/risks identified, with the corresponding services/assistance provided or obtained prior to completion of the assessment should be noted. Example: Client is found to have been abused, neglected, or exploited and the perpetrator still has access to the victim, counselor prepares a legal referral asking that an injunction be obtained; perpetrator is threatening to remove client from a facility, thus endangering client, and counselor confers with legal staff to obtain an order restraining the alleged perpetrator from removing the client pending the completion of an investigation.

SECTION 2 Client's Physical and Mental Health

A. **Client's Physicians/Hospitals** should be listed as well as the dates on which records were requested and obtained.

B. **Client's Medications** should be identified by attaching a copy of the list of current meds from the facility chart.

C. Enter **physical** and/or **mental health problems** of client, whether diagnosed by a physician or identified by the client. Indicate by checking the appropriate box which of these conditions/problems are being treated.

D. Provide a **description of the client's physical appearance and capabilities**.

E. Provide **a description of the manner in which the client communicates** (i.e., by use of hand gestures, eye blinks, communication board, sign language, head nods, non-communicative)**.** If **someone assisted with the interview,** give the **name and relationship of that person.**

F. Indicate by checking the appropriate boxes which **Activities of Daily Living** the client can do independently, with assistance from others, or cannot do at all; it is against medical advice for him/her to do or the client refuses to do. Check all that apply.

G. Refer to General Instructions regarding Risk Factor Checklist and assessing risk.

H. In narrative form, explain and describe how the client's physical/mental status and capabilities affects his/her ability to protect him/herself.

Section 3 Abuse and Neglect (Self-neglect cases require a Form HS- 2861 (817)

A. **Summarize the client's statement** of his/her needs, problems, wishes, or concerns.

B. **List any type of maltreatment identified during the investigation.**

C. **Describe the client's actual condition at the time of the injury/illness.** Attach Body Diagram or Medical Report, if applicable.

D. Self-explanatory.

E. Refer to General Instructions regarding Risk Factor Checklist.

F. Self-explanatory.

G. Self-explanatory.

H. Self-explanatory.

I. Self-explanatory.

J. Self-explanatory.

K. Self-explanatory.

L. Self-explanatory.

M. Summarize **perpetrator's statement** regarding abuse, neglect, exploitation, needed assistance, etc. If perpetrator is not contacted, check appropriate box and explain.

O. Indicate those **Common Warning Signals ("red flags")** which are present by checking "Yes" box, those which are not present by checking the "No" box.

The factors listed are noted to be indicators of potential abuse or neglect. Although they are not positive indications that abuse or neglect are occurring, the presence of these indicators would place the adult at a higher risk for abuse or neglect to occur.

Therefore, the presence of these warning signals requires careful evaluation prior to case closure.

SECTION 4 Financial Resources and Exploitation

This section is optional unless the referral contains allegations of exploitation or some evidence of exploitation is uncovered during the course of the investigation.

A. Enter the **source and amount of financial or in-kind resources** available to client.

B. Enter **amounts of expenses** related to the facility.

C. Give the **name, position or title, phone number and address for the person who is responsible for managing the client's resources.** Check the box indicating the **relationship to the client.**

D. Refer to General Instructions regarding Risk Factor Checklist.

E. Summarize the client's financial situation, explaining any existing risk factors and describe how it impacts the client's safety.

SECTION 5 Environmental Conditions

If there are health or safety hazards which adversely affect the client as a result of living in a facility, check the "Yes" box. If not, check the "No" box. If "Yes", state the conditions, the date and the method by which the conditions were reported to the licensing agency.

SECTION 6 Legal Information

Because clients residing in facilities often have someone designated to act on their behalf and that person will need to be involved in any decisions made, it is important to determine the legal status of the client. Put a check mark in the "Yes" box beside any circumstance which applies. Put a check mark in the "No" box if the circumstance does not apply.

A. If any of the boxes are marked "Yes", provide the name, phone number, location of the document, the court of jurisdiction and the county of jurisdiction.

B. Document any risk pertaining to the client which is related to "A" (i.e., the person holding the durable power of attorney for health care is refusing to allow the provision of critically needed medical treatment or the person holding the durable power of attorney for finances is failing to pay the facility for the client's care, resulting in eviction of the client).

SECTION 7 Support System

Explain any significant relationships the client may have with individuals outside the facility. Explain how those relationships impact the care and safety of the client.

SECTION 8 Summary

Considering all risk factors and all categories of information, determine the overall level of risk and provide supporting documentation of the classification. Consider each area noted within the assessment and weigh each area in relationship to its effect on the other areas of risk and to the client's situation and condition as a whole.

Check the box (es) which indicate(s) what type(s) the case is (may differ from the type of referral). Check all that apply.

Check the appropriate box designating the overall level of risk.

Assign the appropriate classification type as determined by policy in **Section 4-13**. Check the appropriate box.

SECTION 9 Recommendations and Actions Planned

Based on information obtained in the assessment, list any recommendations and define any actions planned which are necessary for the protection of the client.

Supervisor Signature(s)

The signature of the supervisor indicates that the investigative report and assessment has been reviewed and approved by the supervisor. See APS Policy **Section 1-13**, Supervisory Approvals.

SECTION 10 Additional Information

A. Indicate by checking the appropriate box when **a report was made to the person who made the referral to us.** Give **the date**.

B. List any agency from which a **Final Investigative Report was Requested.** Give the **date requested** and the **date received.**

C. List any agency with which **a written copy of the APS Assessment, Report or Findings was shared** (as permitted by policy). Include the **date.**

SECTION 9

SECTION 11 Case Closure

Indicate the **date** the case was closed.

Explain how **the decision to close** was reached**.**

Check the appropriate box to indicate the **level of risk to the client at closure**.

Check the box if there are attachments to the assessment form.

SECTION 12 Interviews

A. List the **date, type of contact, name** and **relationship to the client** of persons interviewed, but who provided no relevant information.

B. List the **date, type of contact, name** and **relationship to the client** of other persons interviewed who provided information ***used in the assessment.***

Tennessee Department of Human Services
Adult Protective Services

CASE CLOSURE SUMMARY

(Check which applies and explain)

Client Name: _____

☐ **Case was valid. Services obtained/provided during investigation/assessment phase reduced or eliminated risk. Explain.**

☐ **Case was valid. A service plan was done and ongoing services were provided that reduced or eliminated the risks to the client. Explain**

☐ **Case was valid. Client refused services. Explain what actions were taken to gain client's cooperation/acceptance prior to closure.**

☐ **Case was invalid. Explain.**

☐ **Other. Explain.**

Select the risk level that most accurately reflects:

OVERALL LEVEL OF RISK (prior to service provision): ☐ High ☐ Intermediate ☐ Low ☐ No Risk

OVERALL LEVEL OF RISK (after service provision): ☐ High ☐ Intermediate ☐ Low ☐ No Risk

Justification for Closure:

Counselor's Name: _____ **Date:** / /

Supervisor's Name: _____ **Date:** / /

FORM 2750 ADULT PROTECTIVE SERVICES
CASE CLOSURE SUMMARY

GENERAL INSTRUCTIONS

Purpose

The Case Closure Summary is used to document the client's circumstances at the time the case is closed and to explain the conditions which support the decision for case closure. Check the appropriate box and provide details for the choice.

Mark the Overall Level of Risk that most accurately reflects the Overall Level of Risk **prior** to Service Provision.

Mark the Overall Level of Risk that most accurately reflects the Overall Level of Risk **after** Service Provision.

Provide justification for the closure decision.

Counselor and Supervisor each sign and date their respective signatures. The signature of the supervisor indicates that the case closure summary has been reviewed and approved by the supervisor. See APS Policy **Section 1-13**, Supervisory Approvals.

The Case Closure Summary HS 2750 is available on the Department of Human Services Intranet.

ADULT PROTECTIVE SERVICES

MULTI-DISCIPLINARY CASE CONSULTATION TEAM

REVIEW NUMBER: _____ **COUNTY:** _____

DATE RECEIVED: _____ **COUNSELOR:** _____

CASE NAME: _____ **SUPERVISOR:** _____

CASE CONSULTATION TEAM RECOMMENDATIONS:

DATE FOR FOLLOW-UP: _____

Tennessee Department of Human Services
Adult Protective Services
LEGAL REFERRAL FOR ACTIONS PURSUANT TO
THE TENNESSEE ADULT PROTECTION ACT
T.C.A. § § 71-6-101 et seq.

PLEASE TYPE OR PRINT LEGIBLY!

Fill out as much as you can. Extra sheets should be added to indicate any other necessary information. Indicate "Yes", "No", "N/A", "See Attached", etc., as needed. Missing items could result in delay. Attach **copies** of doctors' statements. **KEEP "ORIGINALS" OF DOCTORS' STATEMENTS SAFE; THEY MUST BE ATTACHED TO THE ORIGINAL COMPLAINT THAT IS FILED IN COURT.**

1. Adult's Name: _____

2. DOB: _____ Adult's SS#: _____

3. Adult's Home Address: Street: _____ City: _____
Zip: _____ County: _____

4. **NAME** of facility or place where the adult is **NOW** (if different from home address):
_____ Street: _____
City: _____ Zip: _____ County: _____

5. State in narrative form the purpose of this referral:

6. Authority you are seeking from the Court: *(What are you asking the Court to do?)*

☐ **a.** Custody for purposes of placement in a facility by DHS or other individual.
T.C.A. § 71-6-107(a)

Facility Name: _____ Street: _____
City: _____ Zip: _____ County: _____

☐ **b.** Permission for DHS or other individual to consent to medical treatment.
T.C.A. § 71-6-107 (a) or (b)

What Treatment?

6. (Continued) – Authority you are seeking from the Court.

☐ **c.** Permission for DHS or other individual to consent to in-home protective services. T.C.A. § 71-6-107 (b)

What Services?

☐ **d.** Mental or Physical Examination to determine lack of capacity to consent and/or imminent danger. T.C.A. § 71-6-103 (l)

Is this an emergency? ☐ Yes ☐ No

If "Yes", explain.

☐ **e.** Search Warrant, if you are unable to obtain access to the adult. T.C.A. § 71-6-103(f)

☐ **f.** Injunctive Relief. T.C.A. § 71-6-104 (a) *(A court order requiring caretaker or other person to stop abuse, neglect, or exploitation, or to stop interfering with the provision of protective services or requiring protective action).* Note: If the above involves abuse or neglect by a person employed or volunteering in a facility caring for vulnerable persons, see # 25.

☐ **g.** Other:

☐ **h.** Is there a need for the order to be time limited: If so, explain:

☐ **i.** List name, address, telephone number, and relationship to adult of individual, if any, other than DHS, who should be authorized to consent to protective services. T.C.A. § 71-6-107 (a)(1)(A) or § 71-6-107(b)(3)

Name: _____ Relationship: _____

Complete Address and Telephone Number:

_____

7. Give specific examples of the conditions and circumstances of the abuse, neglect or exploitation which make it necessary to seek legal action.

8. Is there resistance to legal action by the adult, family or other person? Yes ☐ No ☐

If "Yes", explain.

9. Give specific indications of the adult's "lack of capacity to consent", i.e., lack of understanding of his/her condition and the risks associated with failing to receive needed care, treatment or services. **OR** when seeking only an order for mental examination, give specific indications that support probable cause to question the adult's capacity to consent.

10. If there is reason to believe that the adult is in "imminent danger" of irreparable harm or death, give specific indications. **OR** when seeking only an order for a physical examination, give specific indications that support probably cause to believe the adult is in imminent danger.

11. List or attach relevant medical information regarding the adult's lack of capacity to consent and/or imminent danger. Attach copy of Form 1125.

12. State the specific service plan for the adult and how the proposed plan will enable the adult to be protected.

13. List efforts that have been made to prevent the necessity of legal action including efforts to allow the adult to remain in the home if you are requesting custody. **THIS MUST BE COMPLETED IN DETAIL BEFORE LEGAL ACTION WILL BE INITIATED.**

14. List names, address and telephone numbers of any spouse, child, sibling, parent, and other relatives involved with the adult.

a. Name: _____ Relationship: _____
Complete Address: Telephone:

b. Name: Relationship:
Complete Address: Telephone:

c. Name: Relationship:
Complete Address: Telephone:

15. List names, addresses and telephone numbers of any other caregivers.
Names:
Complete Address(es): Telephone:

16. Describe willingness and ability of relatives, caretakers, or other persons to act on the adult's behalf to alleviate conditions of abuse, neglect or exploitation.

17. State full names, address, and telephone numbers of Physician/Psychiatrist/Psychologist.

a. Name: _____ Title: _____

b. Name: _____ Title: _____

18. Will the adult pass a PAE for nursing home placement? ☐ Yes ☐ No
If "No", what other placement will be used?

19. State whether or not the adult has been committed to a mental hospital by a Court. List previous mental health commitments including dates.

20. State **FULL** names, addresses, and telephone numbers of witnesses along with the specific **FACTS** each will be able to testify to **from his/her own personal knowledge.**

a. Name: _____
Complete Address: _____ Telephone: _____
Facts to which witness can testify:

b. Name: _____
Complete Address: _____ Telephone: _____
Facts to which witness can testify:

c. Name: _____
Complete Address: _____ Telephone: _____
Facts to which witness can testify:

INCLUDE ADDITIONAL WITNESSES ON ATTACHED SHEETS, IF NECESSARY.

21. State name and address of any previously appointed conservator, any payee for Social Security, SSI or any other public or private benefits, and any person holding a power of attorney for the adult. Attach copy of court order establishing conservatorship and a copy of any power of attorney.

a. Conservator: _____
Complete Address: _____ Telephone: _____

b. Payee and Type of Benefit: _____
Complete Address: _____ Telephone: _____

c. Power of Attorney/Attorney in Fact: _____
Complete Address: _____ Telephone: _____

d. Durable Power of Attorney for Health Care: _____
T.C.A. § 34-6-201

Complete Address: _____ Telephone: _____

22. Does the adult have a living will? ☐ Yes ☐ No
If "Yes" attach copy. T.C.A. § 32-11-101

23. **a.** Include preliminary indications of the financial ability of the adult to secure legal representation and to provide all other necessary expenses of representation in the court proceedings; also include the adult's ability to pay for the services requested.

Example: How will cost of medical care be paid?

b. **CIRCLE** or **UNDERLINE** TYPES OF MEDICAL COVERAGE AND COMPLETE THE FOLLOWING:

1. Name of medical insurance carrier: (Medicare, Medicaid, TennCare, V.A., Champus, M.C.O., B.H.O., other):

_____

2. Policy Number (s): _____

3. Monthly Income Amount: _____ Source: _____

4. Other Income: $_____

5. Real Property Location:

Value: _____

6. Personal Property :

Value: _____

7. Name of Bank(s): _____

8. Bank Account Number(s) and Balance(s): _____

_____ _____

9. Name of prepaid burial contract: _____ Value: _____

10. Choice of cemetery: _____ Amount Owed: _____

11. Debt(s): _____ Amount Owed: _____

12. Expenses: Rent/Mortgage: _____ Monthly Amount: _____

Utilities: _____ Monthly Amount: _____

Other: (describe):

24. If requesting custody for the purpose of placement or medical treatment, is a temporary guardian needed to access and disburse resources? *(Note: A temporary guardian is not a conservator and may only be appointed when custody is awarded. The temporary guardian may only be authorized to pay the costs of care from the adult's resources and may only serve for six months unless the court extends the time for another six months. The temporary guardian is not appointed to have authority over the welfare of the person.)*

T.C.A. § 71-6-107 (a)(6)

Name of proposed temporary guardian: _____

Relationship to Adult: _____

Complete Address: _____ Telephone: _____

25. If you are requesting an injunction against the perpetrator to prohibit him/her from victimizing the adult or other vulnerable persons in an employment or volunteer role (T.C.A. § 71-6-104(b) fill in the following information. **ADD ADDITIONAL SHEETS TO GIVE COMPLETE EXPLANATION OR DESCRIPTION FOR REQUESTED INFORMATION.**

a. Victim's name: _____

b. Name of facility where victim is/was located:

c. Address of facility:

d. Perpetrator's name:

e. Perpetrator's address:

f. What is the specific abuse to the victim?

g. State full names, addresses, and telephone numbers of witnesses along with the specific facts each will be able to testify to from his/her/own personal knowledge.

1. Name: _____

Complete Address: _____ Telephone: _____

Facts to which witness can testify:

2. Name: _____

Complete Address: _____ Telephone: _____

Facts to which witness can testify:

INCLUDE ADDITIONAL WITNESSES ON ATTACHED SHEETS, IF NECESSARY

h. Are there medical reports showing that this abuse of the victim did occur? If so, attach copies. State full names, addresses, and telephone numbers of Physician/Psychologist/Psychiatrist.

1. Name: _____ Title: _____

Complete Address: _____ Telephone: _____

2. Name: _____ Title: _____

Complete Address: _____ Telephone: _____

i. Is there other evidence, in addition to the medical reports, such as pictures, or other witnesses, or other facts which would tend to prove that this person is the only person who could have committed the acts of abuse/neglect? Yes ☐ No ☐

If "Yes", list the items and explain:

ATTACH COPIES OF ANY DOCUMENTATION, PICTURES, LETTERS FROM OTHER FACILITIES, ETC.

j. Has the perpetrator committed these types of actions in other places before? If so, explain what was done, when it was done, where it was done, to whom it was done and any other details that you may have.

k. Has the perpetrator previously been disciplined, charged with and/or prosecuted for these types of acts? ☐ Yes ☐ No If "Yes", explain.

ALL PORTIONS OF ITEMS 26 AND 27 MUST BE COMPLETED.

26. Print or type your name: _____

Telephone: _____ Pager: _____

Office Address: _____

27. Print or type Supervisor's Name: _____

Telephone: _____ Pager: _____

Office Address: _____

Referrals requesting legal action to obtain Court Orders to provide Protective Services should be prepared in duplicate and routed to the Field Supervisor I for review and approval. After approval, the original should be transmitted to the DHS Attorney in the District Office for initiation of appropriate legal action. If consultation with the State Office, Adult Protective Services staff is requested, a copy of the referral and attachments should be sent to the Program Director in the State Office.

YOU MUST NOTIFY THE ATTORNEY IF CIRCUMSTANCES CHANGE AND IMMEDIATELY CALL, FAX OR E-MAIL ADDITIONAL INFORMATION TO THE ATTORNEY.

_____	_____
Signature of Social Counselor	Date
_____	_____
Signature of Supervisor	Date
_____	_____
Date sent to the attorney	Date sent to State Office

Note to Attorney: When legal documents are ready for filing, fax copies for review to Field Supervisor

☐ ***Additional sheets are attached.***

FORM 2752 LEGAL REFERRAL FOR ACTIONS PURSUANT TO TN ADULT PROTECTION ACT

GENERAL INSTRUCTIONS

Purpose

The decision to refer a situation to the DHS attorney for initiation of legal action is made jointly by the APS counselor and the APS supervisor. All petitions must be prepared by the attorney based on information submitted in the legal referral.

The Legal Referral For Actions Pursuant to the Tennessee Adult Protection Act is used to refer information to the DHS attorney when requesting legal intervention for the following purposes:

a. Custody for purposes of placement of the adult in a facility by DHS or other individual.

b. Permission for DHS or other individual to consent to medical treatment.

c. Permission for DHS or other individual to consent to in-home protective services.

d. To obtain a Mental or Physical Examination to determine lack of capacity to consent and/or imminent danger.

e. To obtain a Search Warrant in order to obtain access to the adult.

f. To obtain Injunctive Relief ordering a caretaker or other person to:
    1. stop abuse, neglect or exploitation
    2. stop interfering with the provision of protective services, or requiring protective action.

g. any other request to the court.

There may be some types of legal intervention which require only selective information. For example, evidence of the client's lack of capacity to consent may not be relevant to requesting injunctive relief to stop a person from committing abuse, neglect or exploitation. Each section of the form has clear directions regarding the information that is being requested.

It is essential to fill out the form completely with thorough and accurate information. Obtain any missing information if at all possible. Lack of adequate or accurate information will jeopardize having a successful outcome in court or even the attorney's ability to take the case to court.

The form HS 2752 is available electronically at the Department of Human Services intranet site.

Tennessee Department of Human Services
REFERRAL
to
ADULT PROTECTIVE SERVICES
MULTI-DISCIPLINARY CASE CONSULTATION TEAM

SUPERVISOR: _____ **DATE:** ___/___/_____

COUNSELOR: _____ **COUNTY:** _____

CLIENT'S NAME: _____ **AGE:** _____ **SEX:** _____

EDUCATIONAL LEVEL: _____

REQUESTING OF TEAM:

FINANCIAL RESOURCES: (INCOME AND POVERTY, ETC.)

INFORMAL SUPPORT SYSTEM: (FAMILY, FRIENDS, ETC.)

LIVING ARRANGEMENTS:

PHYSICAL HEALTH:

MENTAL HEALTH:

OTHER AGENCIES:

PRESENTING PROBLEM:

Tennessee Department of Human Services

ADULT PROTECTIVE SERVICES SERVICE PLAN

Client Name: _____

WHAT ARE THE PRESENTING PROBLEMS?

WHAT ARE THE DESIRED OUTCOMES?

LIST THE ACTIVITIES NEEDED TO REDUCE IDENTIFIED RISKS AND OBTAIN NEEDED SERVICES.
Include applicable time frames.

Counselor's Name: _____ **Date:** / /

Supervisor's Name: _____ **Date:** / /

FORM 2754 ADULT PROTECTIVE SERVICES SERVICE PLAN

GENERAL INSTRUCTIONS

Purpose

The Adult Protective Services Service Plan is a post-assessment document. It serves to record those services/tasks/interventions which:

- were identified during the assessment process as being needed to reduce risk and
- are to be provided to achieve reduction of or elimination of risk.

The Service Plan evolves from previous case activities as follows:

- The assessment/investigation identifies those conditions/situations/characteristics that create or contribute to risk;
- The identified risks determine what types of services/interventions are needed to address the risks and achieve desired outcomes;
- Available resources (formal and informal) determine what specific task/services/interventions are planned.

The Service Plan is developed with the knowledge, participation and input of the client to the extent he/she is able, and of all other participants in the plan.

WHEN

The Service Plan is developed with the client whenever on-going, long-term services are to be provided:

- directly by APS
- by other agencies with referral or other involvement from APS
- by family, neighbors, friends, community members or others as a result of APS influence.

It is required to be developed:

- at the point that the assessment is completed
- no later than the time period for assessment as policy provides
- as a requisite for on-going services

The Service Plan is required whenever the assessment is completed and the decision is made to provide on-going services regardless of the time. Services which are provided prior to completion of and during the investigation/assessment period are appropriate to be recorded on page 13 of the APS Case Assessment (Form HS-2861). Those services which are initiated prior to completion of the assessment but continue beyond that period, are documented on **both** Page 13 of the Case Assessment and the APS Service Plan.

The Service Plan is available electronically at the Department of Human Services Intranet site, General Information/Forms.

SPECIFIC INSTRUCTIONS

"WHAT ARE THE PRESENTING PROBLEMS"

The ***Presenting Problems*** are those statements which incorporate the risks that were identified in the assessment. Several problems may be identified for a single case (typically 3-5). Examples of ***Presenting Problem*** statements include:

- Mr. Jones is unable to perform ADLs due to whatever physical/mental conditions render him unable to do so (stroke, dementia, heart disease, etc.).
- Mrs. Smith is at risk due to environmental conditions that put her at risk (hazardous wiring, heating unit exposed to accumulated trash and papers, holes in floors and roof, heating/cooling utilities inoperable, etc.).
- Mr. Johnson has insufficient income to meet his needs due to whatever the cause (funds being misused by grandson, not receiving benefits he is entitled to, etc.).
- Mrs. Davis does not care for herself (take prescribed medication, keep medical appointments, eat enough for minimal nutrition, wanders into traffic, etc.) to ensure basic safety.
- Mr. Bloom is being abused/neglected/exploited by the identified perpetrator (slapped and pinched by his daughter, sexually abused by a nurse aide, his money misused/stolen by his grandson, medication and food withheld by his wife, etc.).

Each Presenting Problem statement should be sufficiently specific so that it describes the client's condition/situation, and is not a generic statement.

"WHAT ARE THE DESIRED OUTCOMES?"

The ***Desired Outcomes*** are those statements that describe the condition/situation which will be achieved by intervention. These statements describe the conditions under which there would not be a need for services and the client would not be at risk. These statements do **not** name the specific services or interventions that will be accessed. There is a corresponding **Desired Outcome** statement for each Problem statement. Examples of ***Desired Outcomes*** include:

- All of Mr. Jones' essential ADLs will be performed, *or* Mr. Jones will have needed assistance to perform ADLs.
- Mrs. Smith will have safe housing appropriate for her needs.
- Mr. Johnson will receive and utilize all benefits and resources for which he is eligible to ensure his needs are met.
- Mrs. Davis's minimal basic needs for health care and safety will be met.
- Mr. Bloom will be safe from neglect, abuse and/or exploitation.

The examples given above of Presenting Problems and corresponding Desired Outcomes are just a few possible statements. The specific Problem and Outcome statements on a plan will vary according to the client's circumstances and will be based on the case assessment findings.

"ACTIVITIES TO REDUCE RISKS AND OBTAIN NEEDED SERVICES. Include applicable time frames."

These are the specific tasks, services and interventions that will reduce or eliminate risk and lead to the desired outcomes. For each Problem/Outcome statement there are appropriate tasks. Tasks and responsibilities:

- clearly name who will do what
- are ***realistic and achievable*** for the responsible party
- involve formal and informal support systems
- show time frames for each task—time frames can designate when a task is to begin, when the task will be completed or intervals at which the task is to be performed.

Following are a few examples of the manner in which tasks may be written with corresponding time frames. The specific tasks on any individual plan will vary with the needs of the client, support systems who are willing and able to assist and from whom the client will accept assistance, and other available resources that the client will agree to accept.

A. The client needs to have a role or task in implementing each intervention to the extent that he or she is able. Even the frail/impaired client's involvement in the plan can be shown with such tasks as "*consider accepting*", "*cooperate with*", "*accept*", "*keep appointments*", "*be available fo*r", etc. The client's tasks need to be realistic for the client to perform and have been discussed with and agreed to by the client. Some examples of tasks for the client include:

Tasks	Time Frames
• Mr. Jones will allow homemaker to perform basic housekeeping listed in the homemaker plan.	• once/wk as scheduled
• Mrs. Smith will apply for home improvement services with Home Grants.	• within 2 weeks
• Mr. Johnson will assist his daughter to ensure his bills are paid and essential needs are met.	• monthly
• Mr. Johnson will cooperate with APS counselor to apply for food stamps.	• June 7th (scheduled appointment)
• Mrs. Davis will dress self and have medicine bottles ready for doctor's appointments.	• as scheduled
• Mrs. Davis will utilize the delivered meals to improve her nutrition.	• immediately & ongoing
• Mr. Bloom will recognize that he deserves to be safe from abusive behaviors.	• ongoing

B. Involve as many different individuals as possible (family, neighbors, friends, community/church groups/members, businesses, mailmen and others who have contact with the client in other capacities). Any individuals who are named in the plan as a part of risk-reduction services need to have agreed to those responsibilities, and the tasks and activities must be realistic and achievable for the person named. The activity must be specific, naming the way(s) in which the person will assist or contribute to the client's safety. Following are some examples:

Tasks	Time Frames
• Son Harry James will bring breakfast to Mr. Jones.	• daily
• Mrs. Clark, neighbor, will unlock Mr. Jones' door to allow homemaker to enter.	• weekly
• Daughter Rita Smith will review utility and other bills and ensure that they are paid.	• monthly and as needed
• Church member Alice Brown will assist Mrs. Davis with transportation for Dr. appointments whenever possible.	• as scheduled.
• Neighbor Arthur Green will notify APS if Mr. Johnson's grandson is seen at the home.	• as necessary

C. It is important to show on the plan the counselor's contribution to risk reduction activities, as it makes it clear to the others who are involved that APS is actively involved. The counselor's tasks, as the others, need to be realistic and achievable for the counselor.

Tasks	Time Frames
• Counselor will assist Mrs. Smith as needed with home improvement application.	• within 2 wks
• Counselor will assist Mrs. Davis to doctor when other transportation is not available.	• as needed
• Counselor will provide counseling and education to Mrs. Bloom about Mr. Bloom's need for assistance with meals and medication.	• within one day and ongoing
• Counselor will maintain contact with Mr. Bloom to provide information and support, and ensure that needed services are implemented.	• at least monthly

These are the activities the counselor performs to enlist the services of other agencies, or to involve other individuals (neighbors, friends, mailman, community or church members, etc. to assist with risk reduction. The tasks that individuals will perform are included in Section B. Following are a few examples of counselor tasks in this area:

Tasks	Time Frames
• Counselor will make referral for Homemaker Services for Mr. Jones.	• within 1 wk
• Counselor will contact Mrs. Davis doctor re: her treatment needs and Home Health Services	• within 2 wks

• Counselor will maintain contact with Mr. Green (neighbor) re: Mr. Bloom's safety.	• at least monthly

Signatures

The date that the counselor signs the plan will serve to show when it was developed following the assessment. An undated signature will be taken to mean that the plan is not in compliance with required time frames. The supervisor's dated signature shows that the plan was reviewed and approved by the supervisor. See APS Policy Section 1-13, Supervisory Approvals.

TENNESSEE DEPARTMENT OF HUMAN SERVICES
APS INPUT FORM

MENU SECTION

New Case: ☐ Approve ☐ Reject

Existing Case: (select one then enter Case I.D.) ☐ Reopen ☐ Reject ☐ Close ☐ Data Change ☐ Delete Case

Case ID: _____ Print Screens? ☐ Yes ☐ No

CASE SECTION

APS Assignment Status: ____

Case Type: ☐ APS Client in Family HM (L) ☐ APS w/ Court Order (M) ☐ APS in Licensed Facility (N) ☐ APS All Other (P) ☐ Family Homes for Adults – Sponsors (Q) ☐ Interstate Services (R) ☐ APS Screen Out (U)

Primary County (Client) _____ Unit _____ Worker _____ Worker Assign Date ___/___/___

Worker County _____ Zip _____-_____ (↑↓ all dates are MM / DD / YYYY)

Application Date ___/___/___ Disposition Date ___/___/___

Review Due Date ___/___/___ Review Complete Date ___/___/___

Aps Rjct Rsn – No Allegation of: ☐ A/N/E, Refer ☐ Impr, Refer ☐ A/N/E or Impr, Refer ☐ A,N,E ☐ Impr ☐ A/N/E or Impr
-- Other Reject Reason ☐ MH/DD Licensed and Operated Facility

INDIVIDUAL SECTION

Action

ID# (Ind.) _____

First: _____ M: ____ Last: _____ Sex: ____ Race: ____

DOB: ___/___/___ Primary Client: ____ Head of Case: ____

Goal Code: 3 Fund Code: 07 SSN: ___-___-___

Gross Monthly Income: $ _____ (← must enter 4 digits – leading zeros required)

Facility Name : _____

Type Report (4 max): ☐ Self Neglect ☐ Neglect ☐ Physical Abuse ☐ Sex Abuse ☐ Emotional ☐ Financial ☐ Other

Initial Risk: ☐ Low ☐ Intermediate ☐ High ☐ No Risk ☐ Low, APS prior to assessment ☐ Intermediate, APS prior to assessment ☐ High, APS prior to assessment ☐ Investigation not completed

Classification: ☐ Valid, Perp Indicated ☐ Valid, Alleged Perp Undetermined ☐ Valid, Perp Unknown ☐ Valid, Perp Unfounded ☐ Valid, No Perp ☐ Valid, Threat of Danger ☐ Invalid, No Services ☐ Invalid, Other Services ☐ Other ☐ Investigation Not Completed

Close Risk: ☐ Low ☐ Intermediate ☐ High ☐ No Risk ☐ Investigation Not Completed

Close Reason (2 max): ☐ Institutionalized ☐ Continued APS Homemaker ☐ Risk Reduced ☐ Refused ☐ Died ☐ Moved / No Location ☐ Other ☐ Died as a result of A/N/E

INDIVIDUAL SECTION

Action

ID# (Ind.) _____

First: _____ M: ____ Last: _____ Sex: ____ Race: ____

DOB: ___/___/___ Primary Client: ____ Head of Case: ____

Goal Code: 3 Fund Code: 07 SSN: ___-___-___

Gross Monthly Income: $ _____ (← must enter 4 digits – leading zeros required)

Facility Name : _____

Type Report (4 max): ☐ Self Neglect ☐ Neglect ☐ Physical Abuse ☐ Sex Abuse ☐ Emotional ☐ Financial ☐ Other

Initial Risk: ☐ Low ☐ Intermediate ☐ High ☐ No Risk ☐ Low, APS prior to assessment ☐ Intermediate, APS prior to assessment ☐ High, APS prior to assessment ☐ Investigation not completed

Classification: ☐ Valid, Perp Indicated ☐ Valid, Alleged Perp Undetermined ☐ Valid, Perp Unknown ☐ Valid, Perp Unfounded ☐ Valid, No Perp ☐ Valid, Threat of Danger ☐ Invalid, No Services ☐ Invalid, Other Services ☐ Other ☐ Investigation Not Completed

Close Risk: ☐ Low ☐ Intermediate ☐ High ☐ No Risk ☐ Investigation Not Completed

Close Reason (2 max): ☐ Institutionalized ☐ Continued APS Homemaker ☐ Risk Reduced ☐ Refused ☐ Died ☐ Moved / No Location ☐ Other ☐ Died as a result of A/N/E

FORM 2785 ADULT PROTECTIVE SERVICES
ACSS INPUT FORM

GENERAL INSTRUCTIONS

Purpose

The Adult Protective Services Input Form is a computer form that tracks essential information about the status of the individual case, as well as collecting vital data about frequency and types of crucial elements of APS program activity that is needed to plan for resources and justify identified needs. This form is completed electronically:

- by Intake when a referral is received
- by Intake or the Investigative unit during the period that the case is open when information changes or new information is received
- by the Investigative unit when the case is ready to be closed.

The form is available at the Department of Human Services Intranet site, General Information/Forms.

Following is the explanation of the specific items.

MENU SECTION

New Case:	To put a case on the system which has not previously been on the system as a closed case nor as an active case. The computer will assign an eleven digit case number to a new case.
Approve:	To open a case for the first time.
Reject:	To Screen Out a report when it has not previously been an open or closed case on the system.
Existing Case:	Case which has previously been assigned a number on the system. It may currently be closed, rejected or an open case.
Case ID	The eleven digit number previously assigned to the case.
Reopen:	To open a previously closed case or rejected case.
Reject:	To screen out a report on a previously closed or rejected case.
Close:	To close an open case.
Data Change:	To change any information on a currently open case.
Delete Case:	Not used by APS program.

CASE SECTION

APS Assignment Status	Priority A, B, C, or D depending on level of risk to the client, according to APS Policy, Section 2-08.
Case Type:	In the first 4 APS case types (L), (M), (N), (P), use the first one which applies. Example: If it is an APS client in a Family Home (L) under a court order (M), mark client in Family Home (L).
APS Client in Family HM (L)	The APS client is currently living in a DHS approved Family Home for Adults foster home.
APS w/Court Order (M)	APS client is currently receiving APS under an APS Court Order.
APS in Licensed Facility (N)	The APS client is currently living in a licensed facility/ institution (this may include MH/DD facilities or nursing homes).
APS All Other (P)	This is an APS case which does not fit any of the first 3 APS case types.
Family Homes for Adult Sponsor (Q)	Family Homes for Adults Sponsor is an individual who has been approved by DHS to provide foster home care for APS clients.
Interstate Services (R)	Case in which the client is in a different state and an agency is requesting assistance from TN APS staff in gathering needed information for completing a home study.
APS Screen-Out (U)	Case in which an adult's situation has been reported to APS intake, but the report does not meet the criteria necessary to accept the report for an APS investigation.
Primary County (Client)	The county of residence for the client.
Unit	APS Unit number to which the case is being assigned for investigation.
Worker	Worker number for worker assigned to investigate.
Worker Assign Date	Six digit date the case is assigned to worker for investigation.
Worker County	Home office county number for the worker assigned to the APS case.

Zip	Zip code of client's address. Complete in all APS cases (at least first five #s +0000).
Application Date	Six digit date the APS report is received by DHS APS intake.
Disposition Date	Six digit date of last transaction on case (approved, reopen, reject, data change or close).
Review Date	Six digit date case is to be reviewed (60 days from date case is assigned for investigation or 6 months or less from last review date).
Review Complete Date	Six digit date the review is completed.
APS Rjct Rsn	APS Reject Reason is the reason the report is not accepted and is not assigned for investigation. The report must meet one of the following conditions to be rejected.

No Allegation of:

A/N/E, Refer	No allegation of abuse/neglect/exploitation but referred for other services.
Impr, Refer	No allegation of physical or mental impairment but referred for other services.
A/N/E or Impr, Refer	No allegation of abuse/neglect/exploitation or impairment but referred for other services.
A/N/E	No allegation of abuse/neglect/exploitation.
Impr	No allegation of physical or mental impairment.
A/N/E or Impr	No allegation of abuse/neglect/exploitation or impairment.

Other Reject Reason:

MH/DD Licensed and Operated Facility	Abuse, neglect, exploitation alleged to have occurred in a licensed and operated facility by the TN Dept. of Mental Health/Developmental Disabilities.

INDIVIDUAL SECTION

Action	This is the type of computer transaction being performed. Insert one of the following letter codes: “A” (Add), “C” (Change) or “D” (Delete).
A = Add	To add previously absent information about the designated individual (i.e., previously unknown birth date, SS#, etc.).
C = Change	To change previously entered data that has changed or is found to be inaccurate (i.e., change in amount of income, incorrect birth date, etc.)
D = Delete	To remove data that was previously entered, with no alternative information to replace the deletion (i.e., remove a middle initial—the client has no middle name, etc.)
ID #(Ind.)	Individual ID #: The eleven digit computer assigned number for the individual whose name and other information is entered in this section. If the individual is new to the system, insert the following information. The computer will assign an individual ID#.
First	First name
M	Middle initial
Last	Last name
Sex	Insert the numerical code that indicates the individual’s sex. “1”=male, “2”=female, “3”=unknown (ACSS Manual, Table #10).
Race	Insert the numerical code that indicates the individual’s race/ethnicity. “1”=White, “2”=Afro-American, “3”=Hispanic, “4”=Native American, “5”=Asian, “6”=Mixed Race, “8”=Unknown (ACSS manual Table #11).
DOB	Date of birth (six digits)
Primary Client	Insert one of the following letter codes. “Y”=Yes, “N”=No.
Head of Case	Primary client who best represents head of the case. “Y”=Yes, “N”=No. There can be only one individual indicated as head of case.

Goal Code	Always goal code 03 in all types of APS cases and Interstate cases.
Fund Code	Always 07
SSN	Nine digit Social Security Number
Gross Monthly Income	If known, fill in client's gross monthly income. (must enter 4 digit's - leading zero's required)
Facility Name	Facility name is entered in those cases in which the alleged A/N/E occurred in a group living arrangement/facility/institution
Type Report (4 Max)	Type of APS Report/Referral, required on approval or reopen.
Initial Overall Risk at the Time of Assessment	The initial overall risk in the APS case as determined by the assessment/investigation and documented on the assessment Form 2861.
Low	The initial overall risk in the APS case as documented on the assessment is low.
Intermediate	The initial overall risk in the APS case as documented on the assessment is intermediate.
High	The initial overall risk in the APS case as documented on the assessment is high.
No Risk	Area of Strength/No Risk
Low, APS prior to Assessment	Level of risk was Low at the time of completion of the initial assessment but protective services had been needed and were provided prior to the assessment 2861 being completed.
Intermediate, APS prior to Assessment	Level of risk was Intermediate at the time of the initial assessment but protective services had been needed and were provided prior to the assessment 2861 being completed.
High, APS prior to protective Assessment	Level of risk was High at the time of the initial assessment and services had been needed and were provided prior to the assessment 2861 being completed.
Investigation Not Completed	Self-explanatory.

Classification:	Classification of APS case, complete when assessment is completed. May enter on review date or at closure. Classification is determined according to APS Policy, Section 4-13.
Valid Perp Indicated	Case Indicated and Perpetrator Indicated.
Valid Alleged Perp, Undetermined	Case Indicated and Perpetrator was Alleged but we were unable to determine who the perpetrator was.
Valid Perp Unknown	Case indicated but the Perpetrator is unknown.
Valid Perp Unfounded	Case Indicated, and it is established that the person alleged to be the Perpetrator is not the Perpetrator.
Valid No Perp	Case Indicated, there is no Perpetrator. (Self Neglect Cases.)
Valid Threat of Danger	Although there is no evidence of A/N/E, conditions of risk place the client in threat of danger.
Invalid No Services	Case Unfounded (no other services needed).
Invalid Other Services	Case Unfounded (services needed other than protective services.)
Other	
Investigation Not Completed	Self-explanatory.
Close Risk:	Rating of Risk at APS Case Closure.
Low	Self-explanatory.
Intermediate	Self-explanatory.
High	Self-explanatory.
No Risk	Self-explanatory.
Investigation Not Completed	Those referrals waiting assignment for which new information is provided indicating the client no longer requires an APS investigation, and the referral is closed from the register without assignment. Also includes cases in which an investigation was started but the client left the state before case was assessed/investigated.

Close Reason:	Reason for Closure of APS Case.
Institutionalized	The client was institutionalized (nursing home, hospital, etc.)
Continued APS Homemaker	The APS case is closed but the client is continued for purchased services: Protective Services - Homemaker Services (contract services).
Risk Reduced	The risks to the APS client have been reduced; APS services are no longer needed and the goals have been met.
Refused	The client, although determined to be in need of protective services, refused APS.
Died	The client died.
Moved/No Location	The client moved and DHS/APS was unable to locate him/her.
Other Includes:	Invalid case, APS not needed.
Died as a result of A/N/E	The client died of causes related to Abuse/Neglect/ Exploitation.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person or organization authorized to receive the information is not a healthy plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Customer Name: _____ SSN: _____-_____-_____

Person/Organization(s) providing the information: Person/Organization(s) receiving the information:

_____ _____
_____ _____
_____ _____
_____ _____

Specific description of information (including date(s) to be provided:

_____

- The customer or the customer's representative must read and initial the following statements:
  - ❑ I understand that my health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. Initials: _____
  - ❑ In understand that I may see and copy the information described on this form if I asked for it, and that I get a copy of this form after I sign it. Initials: _____

- The customer or the customer's representative must read and initial the following statements:
  - ❑ I understand that this authorization will expire on ___ /___ /_____ (DD/MM/YYYY). If no date is specified, this authorization will expire in ninety (90) days from the date of the signature below. Initials: _____
  - ❑ I understand that I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do, it will not have any affect on any actions taken before the revocation was received. Initials: _____

_____ _____
Signature of Customer or Customer's Representative** Date
(Form Must be completed before signing)

Printed Name of Customer's Representative: _____

** There is no need for anyone besides the customer to sign this form, unless you are the customer's "Authorized Representative." If the customer has an Authorized Representative, then the representative should sign his or her name in the place designated for the "Signature of Customer or Customer's Representative". If the Authorized Representative is signing on behalf of the customer, he/she should also print his/her name and relationship to the customer.

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

DEPARTMENT OF HUMAN SERVICES
APS-ADULT FOSTER CARE INVOICE

APS Client: _____ **SSN#:** _____
DOB: _____ **CASE ID#:** _____

PAYEE:

Family Home for Adult*
Sponsor(s) Name: _____
Address: _____
_____
Phone: _____
Sponsor ID# _____
County: _____

Emergency Adult Foster Care
Vendor Name: _____
Address: _____
_____
Phone: _____
Contact Person: _____
Vendor ID#: _____
County: _____

For Period: **From Date:** _____ **To Date:** _____

Contract #: **DP-** _____ **Allotment Code** **345.49** **Cost Center:** **APFC**

***NOTE:** Authorization to Vendor form must be attached each time the contract payment amount changes.

Description of Service	Rate/Month	Date(s) of Service	Sub-Total
Service Fee			
Board			
Emergency Adult Foster Care	Rate/24 hr		

Special Transportation Reimbursement			
Destination (from/to)	**State Rate x Total Miles**	**Date(s) of Service**	**Sub-Total**
	x		
	x		

Total Payment: _____

_____ _____
Signature of Payee **Invoice Date (month and year)**

APS certifies that these services were provided by: ☐ **Adult Family Home Sponsor** ☐ **Adult Foster Care Vendor**

_____ _____ _____ _____
(Print) **APS Staff Name** **Title** **Signature** **Date**

DHS/APS Approval for Vendor Payment:

_____ _____
Signature/Title **Date**

Mail To:
Tennessee Department Human Services:
Fiscal Services Unit - 5th Floor
400 Deaderick St.
Nashville, TN 37248-3200

DHS FISCAL SERVICES UNIT - APPROVAL FOR PAYMENT:

_____ _____
Signature/Title **Date**

AUTHORIZATION TO VENDOR

STATE		VENDOR	
PROGRAM:		**FEIN/SSN:**	
ALLOTMENT:	345.49	**ADDRESS:**	
COST CENTER:	APFC		
DPA#	05-02157-00	**PHONE:**	
		FAX:	
Client Name:			

SERVICE

ITEMS AUTHORIZED	SERVICE DATE(S)	UNITS AUTHORIZED	UNIT COST	AMOUNT AUTHORIZED

TERMS OF AUTHORIZATION

1. The Vendor agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of the authorized service or in the employment practices of the Vendor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

2. The Vendor warrants that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Vendor in connection with any work contemplated or performed relative to this Authorization

3. The State may terminate this purchase without cause for any reason, and such termination shall not be deemed a breach of contract by the State.

4. The Vendor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Vendor, its employees, or any person acting for or on its or their behalf relating to this purchase. The Vendor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this purchase or otherwise enforce the obligations of the Vendor to the State

5. Activities and records pursuant to this Authorization shall be subject to monitoring and evaluation by the State or duly appointed representatives.

6. The State is not responsible for the payment of services rendered without specific, written authorization.

7. The Vendor will submit an invoice in form and substance acceptable to the State to effect payment.

This Authorization To Vendor is issued to be effective (date) _____ and void after the date that the placement Contract changes or terminates.

AUTHORIZATION		ACCEPTANCE	
DATE:		**DATE:**	

ADULT PROTECTIVE SERVICES CASE ASSESSMENT

File Name:

Type of Report	☐	Physical Abuse	☐	Sexual Abuse	☐	Emotional Abuse
	☐	Self Neglect	☐	Neglect	☐	Financial Exploitation

Assignment Status: ☐ A ☐ B ☐ C ☐ D

Date of Referral:

Additional Referrals During Assessment: (date(s))

Priority Register Case: ☐ Yes ☐ No

Assigned To Counselor: Date: Counselor Assigned: (name)

Medical Records:	Requested:	☐	Yes	☐	No	Obtained:	☐	Yes	☐	No
Bank/Financial Records:	Requested:	☐	Yes	☐	No	Obtained:	☐	Yes	☐	No

CLIENT IDENTIFYING INFORMATION WORKSHEET

Client Name: DOB: Age: SS#:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced/Separated

Current Address:

Phone Number(s):

Client lives in:	☐ Own Home	☐ Rental	☐ Other's Home	☐ Homeless
	☐ Institution	☐ Boarding Home	☐ Home Shelter	☐ Other:

Client Representative:	☐ None	☐ Representative Payee	☐ Court Appointed Conservator
	☐ Power of Attorney (POA)	☐ Durable POA-Health Care	☐ Durable POA-Financial

Client Income Source(s):

Finances Managed By: Relationship: Phone:

Income Amount: $ +Food stamps: $ +Other Income: $ =Total Income : $

Rent/Mortgage: Utilities: Phone: Other: Total Expenses:

Significant Others (Spouse, POA's, family, friends, neighbors, etc.):

Name	Relationship	In Home?	Degree of Involvement
		☐	
		☐	
		☐	
		☐	

Services/Community Resources in Place at the Time the Referral was Received:

Name of Service	Services Provided	How Often?

Clients Physicians and/or Hospitals:

Name	Address If Known	Phone Number

File Name:

Client's Physical and/or Mental Health Problems or Conditions:

Condition:	Treated	Untreated
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐
5.	☐	☐
6.	☐	☐
7.	☐	☐

Client's Medications:

Prescriptions and OTC Drugs	Rx Date	Dosage	Frequency	Doctor	Pharmacy
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Client is able to participate in interview: ☐ Yes ☐ No: reason why not:

Client needed assistance during interview: ☐ Yes ☐ No

Date of 1st face to face contact/interview:

Client's Reaction to Adult Protective Services: ☐ Cooperative ☐ Resistant ☐ Uncooperative ☐ Unknown

Client's Response to allegations: ☐ Agrees ☐ Partially Agrees ☐ Denies ☐ Unknown

Client Previously Victimized: ☐ Not at all ☐ One Time ☐ Unknown

☐ Many Times Over A Long Time ☐ Several Times Over A Short Time

Description of Client's actual condition: (attach Body Diagram or Medical report, if applicable)

Summary of Client's statement concerning allegations, needs, problems, wishes or concerns:

File Name:

CLIENT NEEDS ASSESSMENT WORKSHEET

Activities of Daily Living (ADL):
For each activity, indicate functional level of client

Activity	Independently	With Assistance	Not At All	Against Medical Advice	Refuses To Do
Ambulating	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Meal Prep	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Feeding Self	☐	☐	☐	☐	☐
Grocery Shopping	☐	☐	☐	☐	☐
Paying Bills	☐	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐	☐
Taking Meds	☐	☐	☐	☐	☐

Physical/Mental Health Risk Factors:

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Constant Confusion	☐	Periodic Confusion	☐	Minimal Confusion	☐	No Confusion
☐	Profound, Severe Mental Retardation	☐	Moderate Mental Retardation	☐	Mild Mental Retardation	☐	No Evidence of Mental Retardation
☐	Recent Rapid Physical Decline	☐	Client Depressed, Apathetic, lethargic	☐	Minimal Mental Disability	☐	No Evidence of Mental Illness
☐	Recent Rapid Mental Decline	☐	Client Wandering	☐	Minimal Physical Disability	☐	No Evidence of Physical Disability
☐	Chronic or acute potentially life threatening illness or condition	☐	Chronic illness, non life threatening, requiring continuous care or treatment	☐	Generally Compliant with Medical Treatment/Medications	☐	Other:
☐	Severe Mental Illness	☐	Impaired Reasoning	☐	Performs most essential ADL's		
☐	Bizarre/Violent Behavior	☐	Behaviors Indicating Possible Mental Illness		Other:		
☐	Chronic alcohol, substance abuse	☐	Episodic Alcohol, Substance Abuse				
☐	Client Malnourished	☐	Unmanaged Incontinence				
☐	Client Dehydrated	☐	Dental Problems				
☐	Visible Presence of Feces or Urine	☐	Skin Rashes, Discoloration				
☐	Severe Functionally limiting disability	☐	Difficulty ambulating, depends on assistance				
☐	Non compliant with services or treatment	☐	Some assistance needed to meet essential ADL's				
☐	Wandering behavior that places client at risk	☐	Excess Dirt, Fleas on client				
☐	Severe Depression, Suicidal	☐	Client Forgetful				
☐	Bedfast	☐	Other				
☐	Bedsores, Ulcers						
☐	Other						

File Name:

Environmental Risk Factors:

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Eviction Imminent	☐	Deteriorating, Unsound Structure	☐	Household Areas Inaccessible	☐	Sound Structure, no Safety Concerns
☐	Dangerous Accumulation of Trash or Personal Belongings	☐	Broken Windows, Leaks, Holes in Walls or Roof	☐	Minor Repairs Needed in Home	☐	All Areas of Home are Accessible
☐	House is Dangerously Unsafe or Poses an Immediate/Ongoing Threat	☐	Utilities Inoperable or Disconnected	☐	Home is overcrowded, Lack of Privacy	☐	Home is Well Maintained
☐	Residence Poses Special Problems, Placing Client at Imminent Risk	☐	Residence Poses Some Risk, i.e. Client Wanders and Lives Near Major Thoroughfare, Home is in High Crime Area	☐	Minor Housekeeping or Health Issues i.e. garbage or trash containers overflowing, dishes unwashed	☐	Adequate Housekeeping
☐	Toilet Facilities Are Inoperable	☐	Absence of Food Storage	☐	Water, Heat and Other Utilities are in Working Order Most of the Time and Little/No Threat	☐	Adequate Privacy, Sleeping Arrangements
☐	Inadequate Means of Food Preparation	☐	Moderate Pest Infestation	☐	Other:	☐	Heating or Cooling is Adequate
☐	Presence of Human or Pet Feces or Urine	☐	Garbage In/Around House				Other:
☐	Severe Pest Infestation	☐	Exposed Wiring				
☐	Fire Hazards	☐	Heating/Cooling Inadequate				
☐	Utilities Inoperable or Disconnected Posing Substantial Risk to Client	☐	Some Evidence of Excessive Accumulation of Trash or Personal Items				
☐	Client Repeatedly Victimized	☐	Other:				
☐	Living/Sleeping Arrangements Pose Threat						
☐	Extreme Filth						
☐	Other:						

File Name:

Support System Risk Factors:

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Stressed Caregiver	☐	Client Resists Services	☐	Transportation Unreliable	☐	Client Accepts Services
☐	Strained Relationships Within Household or Caregivers Outside of Home	☐	Family/Friends Supportive but Needs Assistance from Agency	☐	Needed Services Are Available with Short Term Waiting List but Temporary Provision In Place	☐	Support System, i.e., Family, Friends, Neighbors, Firmly In Place to Provide Needed Services
☐	Relatives, Friends Unable/ Unwilling To Assist	☐	Family/Friends Supportive but Isolated Geographically	☐	Client/Relatives Have Incomplete Knowledge of Resources	☐	Adequate Services Readily Available
☐	Assistance of Relatives, Friends Inadequate	☐	Public Transportation Unavailable, Inaccessible but Other Options Exist	☐	Other:	☐	In-home Services Available or in Place
☐	Caregiver is the Alleged Perpetrator	☐	Limited Formal Community Resources			☐	Regular Transportation Readily Available.
☐	Client Physically, Socially, or Geographically Isolated from Services/Assistance	☐	Short Term Waiting List No Temporary Provision in Place			☐	Other:
☐	Critical Services not Available	☐	Formal Services Irregular/Unreliable				
☐	Client Has No Transportation Options						
☐	Client Refuses Needed Services/Assistance	☐	Other:				
☐	Client Isolated by Language or Cultural Barriers						
☐	Other:						

Client/Caregiver/Family Dynamics Risk Factors							File Name:
	HIGH		**INTERMEDIATE**		**LOW**		**STRENGTH**
☐	Family in Constant Crisis	☐	Lack of Family Support	☐	Client is Compliant with Some Persuasion	☐	No Special Problems
☐	Disagreement over Shared Responsibilities	☐	Client Demonstrates Excessive Loyalty	☐	Minor Conflicts Among Client/Caregiver/Family	☐	Normal Amicable Relationships
☐	Intergenerational Conflict	☐	Marital Conflict	☐	Some Agreement on Shared Responsibilities	☐	All Agree on Shared Responsibilities
☐	History of Violence in Handling Stress	☐	Inappropriate Responses to Situational Stress	☐	Some Adjustment Needed for Stressful Situations	☐	Very Little Stress-Adjustments Made Easily
☐	Client Fearful of Caregiver/Family	☐	Client Shows No Emotions	☐	Client has Isolated, Minor Episodes of Behavioral Problems	☐	Client Is Generally Compliant
☐	Client is Irrational/ Non-compliant, Disoriented, Critical	☐	Client is Self Blaming	☐	Other:	☐	Client has no History of Behavioral Problems.
☐	Violent/Unpredictable Interactions	☐	Client is Periodically Difficult to Manage			☐	Other:
☐	Client is Provocative, Combative, Disruptive, Violent/Abusive	☐	Client Has Some Episodes of Wandering or Other Behaviors				
☐	Behaviors such as Wandering That is a Danger to Client or Others	☐	Client has Episodes of Being Irritable, Fussy, Unreasonably Demanding				
☐	Caregiver/family Overreact to Stress.	☐	Conflicts between Client and Caregiver				
☐	Tolerance of Abuse/Neglect due to Emotional Dependence on Perpetrator	☐	Other				
☐	Client/caregiver look to Perpetrator for Answers						
☐	Other:						

File Name:

Caregiver Risk Factors				☐	Not Applicable: No Caregiver Present or Identified		
	HIGH		**INTERMEDIATE**		**LOW**		**STRENGTH**
☐	Refuses To Cooperate	☐	Resistant to Cooperate	☐	Reluctant to Cooperate	☐	Full Cooperation
☐	Refuses To Allow Access/Privacy For Client	☐	Inexperienced/ Unrealistic Expectations of Client/	☐	Some Alcohol/Drug Use-No Indication of Negative Impact	☐	No Indications of Current Alcohol/Drug Use
☐	Actively Sabotages Services For Client	☐	Chronic Alcohol/Drug Misuse	☐	Minor Illness or Physical Problem	☐	Good Physical Health
☐	Availability is Questionable	☐	Mild Mental/Emotional Impairment	☐	Needs Some Assistance in Providing Care	☐	No Apparent Mental/Emotional Problems
☐	Reluctant to Provide Care	☐	Deterioration of Physical Health	☐	Minimally Dependent on Client Financially	☐	Knowledgeable About Client's Needs/Abilities
☐	Blaming Client/ Hypercritical	☐	No Contacts Outside Home	☐	Occasional Irritation or Impatience Toward Client	☐	Totally Financially Independent
☐	Financially Dependent on Client	☐	Caregiver Makes Commitment But Does Not Follow Through	☐	Caregiver Marginally Follows Through on Services/Plans	☐	Level of Care is Adequate for the Client's Needs
☐	History of Physically Moving Client to Prevent or Hinder Investigation	☐	Caregiver's Condition Requires Services to Ensure Client Safety	☐	Caregiver's Unrealistic Expectation err on Side of Being Overly Protective or Solicitous of Client	☐	Caregiver is Fully/ Actively Involved with Service Provision and Case Planning
☐	Severe Mental/ Emotional Impairment	☐	Exploitative Behavior/ Resentment To Client Indicated	☐	Other:		Other:
☐	Active Severe Alcohol/Substance Abuse	☐	Attempts to manipulate the Agency and Service Providers				
☐	Despite Evidence, Caregiver Doesn't Believe There is a Problem	☐	Is Inconsistent in Providing Care				
☐	Caregiver has illness or Condition that Severely Impairs Caretaking Capacity	☐	Receives Partial Financial Support. from Client				
☐	Caregiver has Experienced Recent Rapid Decline in Physical Health	☐	Other:				
☐	Demonstrates or Verbalizes Desire to Harm the Client						
☐	Responds to client's behavior w/physical measures (spanking, slapping, smacking) Inappropriate for an Adult						
☐	Demonstrates Poor Understanding of Client's Needs						
☐	Other:						

File Name:

SELF-NEGLECT ASSESSMENT WORKSHEET

Self-Neglect Risk Factors:

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Immediate Hospitalization or Treatment Needed	☐	Prolonged Time Between Illness & Medical Care	☐	Meets Needs For Minimal Medical Care	☐	Seeks Needed Hospitalization or Treatment Immediately
☐	Unable to do ADL's due to Physical/ Mental Limitations	☐	Client Needs In-Home Services to Maintain Independence	☐	Client Meets Own Minimal Needs	☐	Clients Performs All ADL's Independently
☐	Exhibits Constant Confusion	☐	Exhibits Periods of Confusion	☐	Client is Disorganized and Forgetful At Times	☐	Client Exhibits No Mental Health Problems
☐	Constant Failure to Seek or Follow Medical Treatment	☐	Will Seek Medical Treatment but Non Compliant With Orders	☐	Tries To Follow Medical Treatment But Fails To Do So	☐	Compliant With All Medical Treatment Plans and Medications
☐	Unable to Obtain/ Prepare Nutritional Meals	☐	Needs Assistance With Meals or Meal Preparation	☐	Some Meal Preparation is Available But Not Reliable	☐	Client Able to Obtain/ Prepare Meals
☐	Finances not Managed to Meet Basic Needs	☐	Finances are Met on a Sporadic Basis	☐	Meets Minimal Financial Needs	☐	Finances Managed To Meet All Basic Needs
☐	Shelter Inadequate/ Inappropriate	☐	Hoards Trash, Objects, Pets, etc.	☐	Some Clutter/ Chaos In Home	☐	Shelter is Appropriate and Well Maintained
☐	Inadequate Sleeping Arrangements	☐	Clothing Inappropriate for Weather	☐	Questionable Sleeping Arrangements	☐	Appropriate Basic Needs Are Met
☐	Client Unable, Unwilling To Access Resources	☐	Lacks Transportation to Obtain Needed Services	☐	Services are Not Available to Assist Client/Waiting List	☐	Client is Cooperative With Services
☐	Client Refuse/Resists Assistance	☐	Client Reluctant to Admit to Unmet Needs	☐	Obtains Needed Resources With Some Assistance	☐	Independently Accesses Resources
☐	Client Isolated from Family Emotionally, Physically	☐	Conflict With Family Members Over Client's Care	☐	Family is Close To Client But Not Reliable	☐	Family Is Available and Supportive
☐	Ongoing History, Pattern of Self Neglect	☐	Several Previous Reports Increasing in Severity/ Frequency	☐	Previous History of Minor, Low Risk Incidents of Neglect	☐	No Known History of Self-Neglect
☐	A Previous Valid Report/Case	☐	Incomplete Investigation of Previous Report	☐	A Previous Unfounded Report of Self-Neglect	☐	No Previous Reports/ Case of Self-Neglect
☐	Glasses/Hearing and/or Walking Aides Not Provided At All	☐	Client Fails To Use Needed Glasses, Hearing and/or Walking Aid Devices	☐	Client Sometimes Uses Glasses/ Hearing and/or Walking Aid Devices	☐	Client Always Uses Needed Glasses/ Hearing and/or Walking Aides
☐	Regardless of Income, Client Unable or Unwilling to Spend for Necessities	☐	Other:	☐	Other:	☐	Other:
☐	Other:						

File Name:

PHYSICAL ABUSE RISK FACTORS

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Pattern of Serious Injuries	☐	Client Fearful of Others	☐	Accidental Minor Injury -No Long Term Effect	☐	No Evidence of Physical Abuse
☐	Client Has Serious Adverse Psychological Effects of Abuse.	☐	Explanation Inconsistent With Injury	☐	Limited Supervised Contact By Perpetrator	☐	No Access By Perpetrator
☐	Old & New Bruises, Welts or Injuries	☐	Increase of Severe/ Frequent Minor Injuries	☐	Other Adult Protective In Home	☐	Client is Adequately Protected From Any Contact to Perpetrator
☐	Injuries to Head, Face, Genitals	☐	Limited Access to Client By Perpetrator	☐	Other	☐	Client has No Known History of Maltreatment
☐	Injury that Warrants Medical Treatment or Hospitalization	☐	Client Shows Some Adverse Psychological Effects to Abuse, i.e. Fear or Depression			☐	Other
☐	Client Combative, Disruptive, Violent, or Provocative	☐	Nightmares, Night Terrors, Sleep Disturbances				
☐	Improper/Excessive Restraint/Confinement	☐	Other's in the Home-Marginally Protective				
☐	Alleged Perpetrator will not Allow Privacy For Interview or Moves Client to Prevent Contact by the Agency	☐	Previous Report in which Investigation could not be Completed				
☐	Perpetrator Has Full Access to Client	☐	Other				
☐	No Adult Other than Client and Perpetrator in home						
☐	Previous Valid Report of Serious Nature						
☐	Multiple Reports of Maltreatment Involving the Client and/or Perpetrator						
☐	Pattern of increasing frequency or severity of Maltreatment						
☐	Other						

File Name:

FINANCIAL EXPLOITATION RISK FACTORS

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Misuse of Funds That Cause Deprivation of Basic Necessities	☐	Marginal Financial Resources, Barely Able to Provide Necessities	☐	Funds Improperly Used-No/Little Impact	☐	No Access to Funds by Alleged Perpetrator
☐	Pattern of Ongoing Financial Misuse, if Unchecked could Result in Deprivation of Food, Shelter, Medication	☐	Pattern Of Ongoing Financial Misuse that Threatens Client's Well Being	☐	Limited Supervised Access to Resources By Alleged Perpetrator	☐	No Evidence of Financial Misuse - Funds Used Only For Client's Benefit
☐	Client is Unaware of Finances	☐	Bills are Sporadically Paid	☐	Clients Minimal Food/ Medications Needs Met	☐	Client Manages Own Funds Competently
☐	Alleged Perpetrator Has Full Access to Client's Money	☐	Lack of Adequate Supervision or Basic Needs	☐	Client May Sometimes Need Assistance with Money Management	☐	Client is Protected From Any Contact with Perpetrator
☐	Depleted Funds, Questionable Reason	☐	Limited Access By Perpetrator to Client's Funds	☐	Other adult, who Protects, is in Home	☐	Other
☐	Client is Totally Financially Dependent on Others	☐	Client has Sufficient Funds, but Standard of Living is not Consistent with Resources	☐	Other		
☐	Client's Money being Taken	☐	Other				
☐	Client Looking to Perpetrator for Answers						
☐	Other						

EMOTIONAL ABUSE RISK FACTORS

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Client Has Serious Adverse Psychological Effects of Abuse.	☐	Client Shows Some Adverse Psychological Effects to Abuse, i.e. Fear or Depression	☐	Incidents Limited to Verbal Abuse-No Apparent Long Term Effect On Client	☐	No Evidence of Emotional Abuse
☐	Improper/Excessive Restraint/Confinement	☐	Nightmares, Night Terrors, Sleep Disturbances	☐	Caregiver not Attending to Needs – Ignoring Moans or Calls for Help	☐	No Observable Evidence of Neglect
☐	Client traumatized due to prolonged or emotional isolation	☐	Caregiver Yelling, Screaming or Cursing at Client	☐	Caregiver Inattentive to Need for Affection	☐	Client is Adequately Protected From Any Contact to Perpetrator
☐	Alleged Perpetrator will not Allow Privacy For Interview	☐	Caregiver Humiliating, Insulting or Ridiculing Client	☐	Caregiver not Taking Concerns Seriously	☐	Other
☐	No Adult Other than Client and Perpetrator in home	☐	Failure to Provide Psychological Care or Medication for Depression	☐	Lack of Assistance in Doing Activities		
☐	Threatening to Punish or Deprive Client	☐	Client Withdrawn	☐	Caregiver Manipulating Client on How to Feel or Think		
☐	Caregiver Destroying Property or Pets Belong to Client	☐	Other	☐	Caregiver Making Hostile or Mean Spirited Jokes		
☐	Other			☐	Other		

File Name:

NEGLECT RISK FACTORS

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Needed Assistance with ADL's Lacking	☐	Increase of Severe/ Frequent Minor Injuries	☐	Isolated, Explainable Incident of Neglect	☐	No Observable Evidence of Neglect
☐	Client Needing Supervision, Left Alone	☐	Client's Minimal Food/ Medications Needs Met	☐	Accidental Minor Injury -No Long Term Effect	☐	No Access By Perpetrator
☐	Pattern of Increasing Frequency or Severity of Maltreatment	☐	Needed Hearing Aid, Glasses, Dentures Withheld/Not Provided	☐	Limited Supervised Contact By Perpetrator	☐	Client is Adequately Protected From Any Contact to Perpetrator
☐	Immediate Intervention, Required to Prevent Risk of Death, Serious or Irreparable Harm	☐	Prolonged Time Between Minor Illness/Injuries and Medical Care	☐	Other Adult Protective In Home	☐	No Known History of Maltreatment
☐	Prolonged Time Between Serious Illness/Injuries and Medical Care	☐	Lack of Adequate Supervision or Basic Needs	☐	Previous Report or History of Neglect that was Low Risk	☐	Other
☐	Misuse of Funds That Cause Deprivation	☐	Bills are Sporadically Paid	☐	Other		
☐	Client traumatized due to prolonged or emotional isolation	☐	Food or Medicine Inconsistent with Condition				
☐	Alleged Perpetrator will not Allow Privacy For Interview	☐	Caregiver is inconsistent in meeting minimum needs				
☐	Client Looking To Perpetrator for Answers	☐	Other's in the Home Marginally Protective				
☐	No Adult Other than Client and Perpetrator in home	☐	Overgrown nails				
☐	Caregiver Moves Client to Prevent Interview or Contact by Agency	☐	One Previous Valid Report of Neglect that Placed Client in Immediate Danger				
☐	Other	☐	Previous Report of Maltreatment in which Investigation could not be Completed				
		☐	Other				

File Name:

SEXUAL ABUSE RISK FACTORS

	HIGH		INTERMEDIATE		LOW		STRENGTH
☐	Injuries to Genitals, Upper Torso or Inner Thighs	☐	Client Fearful of Others	☐	Limited Supervised Contact By Perpetrator	☐	No Evidence of Sexual Abuse
☐	Old & New Bruises, Welts or Injuries	☐	Explanation Inconsistent With Injury	☐	Other Adult In Home Protective	☐	No Access By Perpetrator
☐	Client is Non-Verbal, Unable to Communicate	☐	Nightmares, Night Terrors, Sleep Disturbances	☐	Client has Some Barriers to Communication	☐	Client is Adequately Protected From Any Contact to Perpetrator
☐	Immediate intervention, i.e. Hospitalization, or Emergency Services Needed	☐	Client Shows Some Adverse Psychological Effects to Sexual Abuse, i.e. Fear or Depression	☐	Other	☐	Other
☐	Client Combative, Hostile or Sexually Acting Out	☐	Limited Access to Client By Perpetrator				
☐	Genital or Urinary Tract Irritation, Infection or Scarring	☐	Other's in the Home-Marginally Protective				
☐	Evidence of Sexually Transmitted Disease	☐	Client has Limited Ability to Communicate				
☐	Any Non-Consensual Sexual Activity/Contact	☐	Other				
☐	Improper/Excessive Restraint/Confinement						
☐	Alleged Perpetrator will not Allow Privacy For Interview						
☐	Client Looking To Perpetrator for Answers						
☐	Alleged Perpetrator Has Full Access to Client						
☐	No Adult Other than Client and Alleged Perpetrator in Home						
☐	Inadequate sleeping arrangements						
☐	Client Forced to View Pornographic Material						
☐	Client Forced to Witness Sexual Acts						
☐	Forced Nudity, not Allowed Privacy for Bathing, Dressing						
☐	Fondling, Touching, Kissing in a Sexual Manner						

PERPETRATOR INTERVIEW WORKSHEET

Contact made with perpetrator: Yes ☐ No ☐ N/A ☐

Alleged Perpetrator Name	Relationship To Client	Contact With Client	Reaction To APS	Response To Allegation

Summary of Perpetrator Statement concerning A/N/E, needed assistance, etc. If no contact made, reason why not:

File Name:

OVERALL ASSESSMENT AND RISK LEVEL SUMMARY

List any other type of maltreatment identified during the investigation:

☐	Self Neglect	☐	Neglect	☐	Physical abuse	☐	Financial Exploitation	☐	Sexual abuse	☐	Emotional abuse

Considering all risk factors and all categories of information, determine the level of risk in each area**, prior to APS intervention**. Create a "picture" of how the client's situation looked before APS did anything.

Area Assessed	Risk Level Assigned			
	High	Intermediate	Low	Strength
Activities of Daily Living (ADL's)	☐	☐	☐	☐
Physical/Mental Health	☐	☐	☐	☐
Environment	☐	☐	☐	☐
Support System	☐	☐	☐	☐
Client/Caregiver/Family Dynamics	☐	☐	☐	☐
Caregiver Risk	☐	☐	☐	☐
Self-Neglect	☐	☐	☐	☐
Physical Abuse	☐	☐	☐	☐
Financial Exploitation	☐	☐	☐	☐
Emotional Abuse	☐	☐	☐	☐
Neglect	☐	☐	☐	☐
Sexual Abuse	☐	☐	☐	☐

Select the overall level of risk that most accurately reflects the client's circumstances **prior** to APS Intervention:

High	☐	Intermediate	☐	Low	☐	Strength/No Risk	☐

Considering all risk factors and all categories of information, determine the **current** overall level of risk and provide thorough supporting documentation. Identify services provided to reduce risk.

Select the **overall level of risk** that most accurately reflects the client's **current** circumstance:

High	☐	Intermediate	☐	Low	☐	Strength/No Risk	☐

File Name:

CASE CLASSIFICATION WORKSHEET

Assign the appropriate classification type for **all** allegations:

Type of A/N/E	Indicated	Unfounded	N/A
Self Neglect	☐	☐	☐
Physical Abuse	☐	☐	☐
Financial Exploitation	☐	☐	☐
Emotional Abuse	☐	☐	☐
Neglect	☐	☐	☐
Sexual Abuse	☐	☐	☐

☐ **Valid Case:**

- ☐ Case Indicated/No Perpetrator (Self Neglect)
- ☐ Case Indicated/Perpetrator Indicated
- ☐ Case Indicated/Perpetrator Unknown
- ☐ Case Indicated/Alleged Perpetrator-Not able to Determine
- ☐ Case Indicated/Perpetrator Unfounded
- ☐ Case Indicated/Threat of Danger

☐ **Invalid Case: Case Unfounded**

CASE DECISION WORKSHEET

- ☐ Case Valid: Services Provided during Investigation/Assessment Phase/ Risks Reduced or Eliminated – Close Case on form 2750
- ☐ Case Valid: Need for on-going Services – Proceed to Service Plan form 2754
- ☐ Case Valid: Client Refused Services – Close Case on form 2750
- ☐ Case Invalid: No Services Provided during Assessment Phase/ No need for On-going Services –Close Case on form 2750
- ☐ Client deceased – Close Case on form 2750
- ☐ Investigation/Assessment Incomplete – No classification possible – Close Case on form 2750

ADDITIONAL INFORMATION

Report made **at the conclusion of the investigation** to the person making the referral:

☐	Yes	Date:	
☐	No	Explain:	

Assessment Completed by:		Date Completed:	
Assessment Reviewed and Approved by:		Date:	

ADULT PROTECTIVE SERVICES
CASE ASSESSMENT
HS-2861
GENERAL INTRUCTIONS

Purpose

The Case Assessment is a post-investigative document, to assist counselors in determining the strengths, weaknesses, needs, and risks in adult protective service cases. The assessing/determining of risk is an ongoing process beginning with the initiation of the investigation. This assessment will then serve as a basis for planning the activities of the client, counselor, other agencies or individuals involved in reducing risks by meeting identified needs. The form HS-2861 is available electronically on the Department of Human Services Intranet.

Initiation of the Form

The ***Case Assessment***, Form HS-2861 is to be completed **at the conclusion of the investigation**, within 60 days or less of the initial referral being assigned for investigation.

A **new assessment** should be done:

- **Upon receipt of a report containing new allegations.**

  If the new report is received before the initial investigation has been completed, the narrative should reflect the receipt of the new referral and the results of the investigation of the new allegations should be documented in the current assessment.

  If a case has been assessed, but not closed on the system and no services are being provided, and a new referral is received with the same allegations, the counselor will need to go out, document in the narrative that the referral was responded to and refer to the information that was documented on the previous assessment. (If the receiving supervisor makes the decision that there is not a need to respond, that decision should be included in the case file either in writing or in the form of an e-mail.)

  If a case is active and services are being provided, the receipt of a new report containing new allegations will require that the new allegations be investigated and assessed, but it should not be necessary to complete an entire new assessment document. The new report can be assessed and documented using the pages from the assessment tool that apply to the determination of levels of risk and the classification of the findings. The findings may or may not impact the service plan. If there is identification of the need for a new intervention, it can be added to the existing service plan. A copy should be filed chronologically within the narrative.

- **Any time a referral is received that re-opens a closed case.**

  If a report is made and accepted by Intake as meeting the criteria for assignment and investigation, Intake must take the report and re-open the closed case. If the receiving supervisor feels that the information in the referral has recently been investigated or that the allegations involve a client who has capacity and who has refused services and the allegations have previously been investigated, the FSI may make the decision to not assign

the report for investigation, but instead, close the report on ACSS with a closure reason of "Investigation Incomplete". The FSI should provide the caseworker with that decision either in writing or in an e-mail that can be included in the case file to document the reason the report was not investigated.

- **Each primary client in a case will need a complete, separate assessment.**
- **At any point in the case, at the discretion of the supervisor, when it is felt that there have been significant changes that may impact the safety of the client.**

Preparing for the Assessment

An accurate, thorough case assessment is dependent upon a thorough investigation being conducted, including face-to-face and other contacts with client, relatives, friends, physicians, other agencies or significant individuals, as appropriate. While counselor observation is crucial in investigation and assessment, the involvement of others with day-to-day knowledge or with expertise regarding the client's situation will provide information not readily visible to the counselor. Such information may either confirm or contradict initial counselor observations or client statements. **The completed case assessment should accurately reflect the circumstances that exist at the time it is written, once the investigation is complete, and reflect changes that have occurred since initiation of the case.**

Conditions/Actions Prior to, During and After the Assessment

The counselor is responsible within the document to deal with two time frames:

1. **Past-Prior to APS Intervention**

   Occurrences or situations that have existed or are present at the initiation of the case, prior to completion of the assessment, should be addressed in three ways:

   a. Risks/dangers that were identified **prior** to the assessment being completed and which required intervention **before** the assessment was completed should be noted in the appropriate summary section on page 13. Space is provided for the counselor to list the risk(s)/danger(s) identified and the assistance or services provided or obtained to reduce that risk.

   b. Completion of the Assessment (Form HS-2861) allows reduced dictation/case recording in cases in which only a few contacts are needed. However, the information obtained and used in decision-making must be clearly represented on the Form. If it is not, then narrative recording of contacts should support all information contained in the assessment. Changes in the client's situation during or prior to the assessment period, whether as a result of APS intervention or the activities of others, can be described in the narrative dictation contacts.

   c. When there is a marked change in the level of risk between the time that the referral is received and when the assessment is completed and documented, the changes and their causes should be clearly explained and described.

d. Those things that are expected to occur and activities to be completed by the client, counselor, or others in addressing client needs/risks are to be documented on the Adult Protective Services Service Plan, Form 2754.

Risk Factor Checklist, Conclusion and Assessment of Risk

Throughout the case assessment, the counselor is expected to look critically at the client's situation to determine what the client wants, to identify strengths, weaknesses, client needs and available resources to meet needs. In documenting the assessment, the counselor is to supply basic information relevant to five major areas of a client's life:

1) Client's physical/mental health, including what the client can and cannot do for him/herself;
2) Environmental conditions, which include:
    a. structural soundness
    b. the appropriateness of housing for the client's needs, regardless of the condition
    c. cleanliness/sanitary/health conditions
3) Financial resources/financial exploitation related to assets being adequate for the client's needs, the client being financially independent from others and the client's ability to manage and be in control of his/her funds, whether or not others are mismanaging funds or exploiting the client
4) Abuse, (self) neglect and exploitation factors, and
5) Support systems including informal and formal sources for assistance.

Having provided basic information requested in each of these areas, the counselor then determines the level of risk to the client in each area separately from the other areas. To assist in determining and documenting the level of risk, counselors are provided with a **list of risk factors** for each area. While the list of risk factors is not exhaustive, it contains factors identified by Tennessee social counselors and confirmed by national experts as relevant in assessing adult cases. When factors exist within a particular situation that are different from those factors in the list provided, the counselor is to **add** these to the list of risk factors.

Within each risk factor list, a check will indicate the factor is present. No check indicates that information regarding that factor is not present. Risk factors which are present but not listed should be documented in the "other" category. Each checklist is intended to guide a counselor in thinking through the process of assessment and in documenting the level of risk to the client. It should not be utilized as the sole basis for assessment in a case.

After completing the risk factor checklist for each area, the counselor then explains, in the **Overall Assessment and Risk Level Summary**, using specifics and details, how the client and the client's circumstances are affected. The counselor should note all relevant facts, which contribute to the level of risk to the client, changes, client strengths, and significant problems identified to **determine** and to **justify** the level of risk.

Determining and Assigning Level of Risk

In determining the level of risk to a client, the counselor has two tasks:

1. First, the counselor must examine each of the areas previously mentioned independently and in isolation from the other areas. In doing so, the counselor, in effect, puts "blinders" on when considering the various facets of a client's life.

EXAMPLE: Client is bedfast, totally dependent on others for personal care and basic needs.

In assessing the client's physical/mental health, the fact that the client is unable to protect him/herself and must depend on others for basic needs places the client at **high** risk **physically**. However, if the client was found to have consistent caregivers who were willing and able to meet most or all of the client's needs, the client's **support system** would be determined to be an **area of strength.**

2. The second task of the counselor is to remove the "blinders" and consider the total picture in order to determine the **overall** level of risk. In the example above, the client would likely be found to be at low risk or no risk overall, based on the consistent involvement of competent caregivers which reduces or eliminates the risk posed by the client being bedfast and totally dependent.

Professional discretion is necessary on the part of the counselor in assigning the particular level of risk for a case overall or for individual areas. The risk factors provided will serve as a tool in determining levels of risk. Look for similarities between the client's situation and the examples provided on the assessment tool. In addition, the following broad guidelines should be used in assigning risk levels:

Recognizing that risk is on a continuum and interventions are on a continuum, many individualized factors will go into deciding the most appropriate level of each. Generally, if the level of risk falls between points on the continuum, treat it as being at the higher level of risk; for example, if a situation falls between **Low** and **Intermediate** levels of risk, treat it as being a condition of **Intermediate** risk. The following questions may also assist in determining the most accurate risk rating of a client's current condition or situation:

- What will happen to the client if APS does not intervene?
- How urgent, complex and serious is the client's situation?

Once the relevant information is reviewed, the counselor will need to decide whether any of the following are present:

Risk or existence of physical or mental injury, serious illness, sexual abuse, risk of death, or irreparable harm.

The more immediate and severe the risk or presence of the above conditions, the higher the risk to the client. When the likelihood of such conditions is less immediate or serious, then the risk to the client is lower.

Some examples of each level of risk follow:

High Risk – A client who is ill, or has all their resources taken, or is subject to abusive acts, or is left without a caregiver or other support will likely be at high risk in each of these areas. This situation will require that care or intervention be planned and acted upon quickly. Multiple services may be needed. Court action may be required, or continuous or frequent involvement by the counselor or others may be necessary to protect the client and/or meet basic needs.

Intermediate Risk – The client at intermediate risk may have more strengths within a given area than a high risk client. For example: The adult may be ill, or mistreated, or have inadequate support, but the situation is less severe and, without endangering the client, the counselor can take more time to respond. A caregiver who needs support or needs to learn better methods may put the client at intermediate risk, as opposed to the absence of a caregiver or the presence of a violent mentally ill caregiver which places the client at higher risk.

Low Risk – The problems encountered at this level are least likely to cause serious danger to the adult. The risk may be very limited. When the risk to the client is borderline, there must be clear reason to expect continued deterioration. A low risk case may be a client who is dependent on a caregiver who cannot always respond to the client's needs without assistance from an agency or another person. A low risk case may need only limited contact, authorization of an existing service, or development of support or encouragement for a client to relieve the risk.

Areas of Client Strength should indicate specific areas of a client's life which pose no risk/danger to the client and which actually are strengths on which to build. For example: the client has adequate resources that are well managed or has safe and adequate housing. In some cases, areas of strength may serve to reduce risk in other areas. In other cases, the areas of strength may not have an impact on what creates risk for the client.

Overall Risks – The overall rating will take into account the risk of physical/mental injury, sexual abuse, self-neglect and/or exploitation, and the likelihood of serious illness or death of the adult if intervention/services are not provided. The level of Overall Risk will balance areas of high and intermediate risk with the impact of areas of low risk and strengths, if any, on reducing the effect of risks on the client's safety.

The counselor will determine the rating to assign, once the impact of each area is carefully weighed, and the overall likelihood of the most serious consequences as listed above is determined. When assigning the overall rating it will be helpful to consider the **immediacy**, **intensity** and **frequency** of the services or interventions required by the client's situation. The final overall rating will be the indication of the level of need for attention and counselor involvement required by the case as a whole, as well as consideration of the case classification. (**See Section 4-13**)

Note: When the Overall Risk level at the time of completing the assessment is lower than the Overall Risk level to the client at the time the investigation was initiated and/or earlier during the assessment period because of activities/interventions/services which took place during the assessment period, fully document and describe the Overall Risk to the client at its **highest level from the point the case was initiated**, and explain what has occurred to reduce the Overall Risk.

SPECIFIC INSTRUCTIONS

The counselor should complete a separate assessment for each client in a household.

File Name is the name of the client.

Type of Report – Counselor should mark each type of maltreatment alleged in the referral.

Assignment Status – Select status as assigned by intake or by the FSI if referral has been on the Investigative Priority Register.

SECTION 9

Date of Referral – The date the report was received by intake.

Additional Referrals During Assessment (date(s)) – List date(s) of any additional referrals received during the investigative/assessment phase.

Priority Register Case – Check the box to indicate whether or not referral was initially placed on the Investigative Priority Register.

Assigned to Counselor (date) – Indicate the date the referral was assigned to a counselor for investigation.

Counselor Assigned (name) – Identify, by name, the counselor to whom the referral was assigned.

CLIENT IDENTIFYING INFORMATION WORKSHEET

Counselor should complete identifying information for client.

Client Name – Indicate first, middle name or initial, last name of person who is the client in the case.

DOB – Date of Birth of client

Age – Age of client.

SS# - Social Security number of client

Marital status – Check the box that indicates the marital status of the client.

Current Address – Give the address where the client currently resides.

Phone Number(s) – Number at which the client can most frequently be reached, as well as any other numbers available for the client.

Client lives in – Check the box that most clearly reflects the client's living arrangement.

Client Representative – Check the box that most accurately reflects whether or not the client has someone identified or appointed to act in his/her behalf.

Client Income Source(s) – List the source(s) of the client's income (i.e., Social Security, SSI, VA,)

Finances Managed by – Identify by name the individual responsible for managed the client's finances. If managed by self, please indicate "self".

Relationship – What is the relationship to the client of the person managing the client's finances? If self, leave blank.

Phone – What is the phone number of the individual responsible for managing the client's finances? If self, leave blank.

Income Amount – the amount of the client's income

Food stamps – If the client receives food stamps, give the amount

Other Income – List any other sources of income

Total Income – What is the total income for the client, taking into account all of the above.

Rent/Mortgage – What is the amount the client pays as rent/mortgage?

Utilities – What is the amount the client pays for utilities (i.e., water, electricity, gas, etc)?

Phone – What is the amount the client pays for telephone service?

Other – What other regular expenses does the client have?

Total Expenses – What is the total amount of the regularly occurring expenses for the client?

Significant Others – self-explanatory

Services/Community Resources Already in Place at Time of Referral – self-explanatory

Clients Physicians and/or Hospitals – self-explanatory

Client's Physical and/or Mental Health Problems or Conditions – Enter physical and/or mental health problems of client, whether diagnosed by a physician or identified by the client. Indicate by checking the appropriate box which of these conditions/problems is being treated.

Client's Medications – Enter names of client's medications both prescription and over-the-counter, dates of prescriptions, dosage, how often taken, prescribing physician and pharmacy.

CLIENT INTERVIEW WORKSHEET

Client is able to participate in interview – self-explanatory

Client needed assistance during interview – Indicate whether or not the client required the use of special equipment (dolls, language board, cards, etc.) or an interpreter in order to participate in the interview process.

Date of 1st face-to-face contact/interview – self-explanatory

Client's Reaction to Adult Protective Services – Check the box that indicates the type of response encountered from the client

Client's Response to the Allegations – Check the box that best describes the client's response to the allegations

Client Previously Victimized – self-explanatory

Description of Client's Actual Condition – self-explanatory

Summary of Client's statement concerning allegations, needs, problems, wishes or concerns – self-explanatory

CLIENT NEEDS ASSESSMENT WORKSHEET

Activities of Daily Living (ADL) – Indicate by checking the appropriate boxes which Activities of Daily Living the client can do independently, with assistance from others or with an appliance, or cannot do at all; it is against medical advice for him/her to do or the client refuses to do. Check all that apply.

Physical/Mental Health Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

Environmental Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

Support System Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

Client/Caregiver/Family Dynamics Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

Caregiver Risk Factors – Caregiver/Caretaker is defined as ***an individual or institution who has the responsibility for the care of the adult as a result of family relationship or who has assumed the responsibility for the care of the adult person voluntarily, by contract or agreement.*** Refer to General Instructions regarding the risk factor checklist and assessing risk. If there is no caregiver present or identified, mark the box that indicates this and move to the next section.

Self-Neglect Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk. ***Because Self-Neglect is often present in conjunction with A/N/E by others, the counselor should carefully review the risk factor lists associated with self-neglect regardless of whether or not self-neglect was alleged in the referral.***

Physical Abuse Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

Financial Exploitation Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

Emotional Abuse Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

Neglect Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

Sexual Abuse Risk Factors – Refer to General Instructions regarding the risk factor checklist and assessing risk.

PERPETRATOR INTERVIEW WORKSHEET

Contact made with perpetrator – Check the appropriate box to indicate whether or not contact was made with the perpetrator. If there is no perpetrator (as in a self-neglect case) check the N/A box.

Alleged Perpetrator Name – Self-explanatory

Relationship to Client - Self-explanatory

Contact with Client – Indicate how often the alleged perpetrator has contact with the client.

Reaction to APS – What is the alleged perpetrator's reaction to APS intervention?

Response to Allegation – What is the alleged perpetrators response to the allegations?

Summary of Perpetrator Statement concerning abuse, neglect, needed assistance, etc. including an explanation of why the perpetrator was not interviewed, if that was not done – Self-explanatory

OVERALL ASSESSMENT AND RISK LEVEL SUMMARY

List any other type of maltreatment identified during the investigation – Self-explanatory

Considering all risk factors and all categories of information, determine the level of risk in each area, **prior to APS intervention**. This would be a "picture" of how the client's situation looked **before APS did anything**.

Select the **overall** level of risk **prior** to APS intervention – Considering all risk factors and all categories of information, determine the overall level or risk that existed for the client **before APS did anything.**

Considering all risk factors and all categories of information, determine the **current** overall level of risk and provide thorough supporting documentation. Identify services provided during the investigative/assessment phase to reduce risk – Consider each area noted within the assessment and weigh each area in relationship to its effect on the other areas of risk and to the client's situation and condition as a whole. Provide supporting documentation that identifies the services provided to reduce risk and describe how the risk level was changed by the provision of services. Pay particular attention that risk factors marked and information provided in the narrative support each other.

Select the **overall level of risk** that most accurately reflects the client's **current** circumstances.

Check the box that most accurately describes the level of risk at the present time.

CASE CLASSIFICATION WORKSHEET

Assign the appropriate classification type for all allegations – Assign the appropriate classification type as determined by policy in **Section 4-13**. Check the appropriate box for each type of maltreatment. Check the box that most accurately reflects the valid case type, or if appropriate, check Invalid Case: Case Unfounded.

CASE DECISION WORKSHEET

Check the box that most accurately describes the action you plan to take regarding the case from this point in the process.

ADDITIONAL INFORMATION

Report made at the conclusion of the investigation to the person making the referral – Indicate by checking the appropriate box if a report was made to the person who made the referral to us. Give the date the report was made. This date should reflect a contact made following the investigation and assessment as to whether or not APS plans to continue involvement with the client. The narrative should support the contact date recorded.
If no contact was made with the referent, explain why not.

Assessment completed by – The name of the individual completing the assessment

Date Completed – Indicate the date the assessment form is being completed. Absence of a date will be presumed to be an indication that the work was not done within the policy guidelines for time frames.

Assessment Reviewed and Approved by – The name of the individual who read and approved the work done in assessing the case. Signatures of supervisors indicate that the assessment as been reviewed and approved by the supervisor. (See Section 1-13, Supervisory Approvals)

Date – Indicate the date the assessment was reviewed and approved.

SECTION 10 - GLOSSARY

Abuse -
The infliction of physical pain, injury, mental anguish or unreasonable confinement of an adult who is unable to protect him/herself.

Activities of Daily Living -
The performing of those tasks necessary to maintain an independent household and to take care of personal needs. The tasks include use of telephone, use of public transportation or driving a car, doing own local shopping, own cooking, doing light housework, heavy housework, taking necessary medication, keeping track of money, paying bills, dressing self, grooming and cleaning self, getting in and out of bed, taking a shower or bath, and toileting.

Addiction -
Psychological dependence on the use of alcohol, narcotic drugs, analgesics or other chemical substances to the extent that a physiologic need becomes established.

ADL's -
Abbreviation for Activities of Daily Living. See above definition.

Adjustment Disorder -
A maladaptive reaction occurring within three months after the individual is subjected to specific, identifiable stress such as divorce, financial crises, family discord, a natural disaster or retirement. This is not merely a single instance of over reaction but involves impairment in social functioning and unexpectedly severe symptoms.

Adult -
A person 18 years old or older who because of mental or physical dysfunctioning or advanced age is unable to manage such person's own resources, carry out the activities of daily living, or protect such person from neglect, hazardous or abusive situations without assistance from others and who has no available, willing and responsibly able person for assistance and may be in need of protective services.

Adult Foster Home/Adult Family Home -
A family living arrangement for APS clients who are unable to live independently but do not require institutional or nursing care and whose own families are unable to care for them. These homes can house up to three (3) APS clients and are studied, approved, and supervised by DHS.

Advanced Age -
Sixty years of age or older.

Advocate -
A person who argues for or pleads in another's behalf.

Affect -
How a person feels and how they show that feeling through facial expressions, pitch of voice, and the use of hand and body movements.

Affidavit -
A written statement of facts or opinion based upon facts, signed in the presence of a notary public or a judge or other person having authority to administer oath.

Ageism -
The tendency to stereotype and discriminate against elderly as debilitated, inadequate, or unable to fend for themselves; and, therefore, to overlook their potential for making positive contributions to society and to the solution for their own problems.

Agitation -
Excessive motor activity that usually has no purpose and is related to internal tension. For example: inability to sit still, pacing, fidgeting, wringing of hands or pulling at clothes or hair.

Allegation -
An assertion of fact or suspicion that has not yet been substantiated.

Alleged Perpetrator -
The individual who is said to have abused, neglected or exploited an aged or disabled adult.

Alzheimer's Disease -
Primary degenerative dementia characterized by a loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning. The deficit is multifaceted and involves memory, judgment and abstract thought. Changes in personality and behavior also occur.

A/N/E -
Abuse, neglect or exploitation.

Anxiety -
Apprehension, tension or uneasiness resulting from some threat or danger which is not recognized by the person.

Assisted Living -
Programs that provide housing in a group setting for individuals with disabilities. May include 24-hour attendant care, medication supervision, personal care services, transportation and other supportive services.

Body Language -

The expression of unconscious or unspoken feelings, thoughts, opinions and conflicts through posture, gesture, facial expression, physical distance/closeness and other forms of non-verbal communication that have meaning within the context in which they appear.

Bone Fractures -

A fracture or a broken bone. There are ten types of fractures, the most common are:

Simple - the bone is broken, but there is no external wound.

Compound - the bone is broken, and there is an external wound leading down to the site of the fracture, or fragment of bone protruding through the skin.

Complicated - the bone is broken and has injured some internal organ, such as a rib piercing a lung.

Spiral - twisting causes the line of the fracture to encircle the bone in the form of a spiral.

Brain Damage -

Injury to the large soft mass of nerve tissue contained within the cranium/skull.

Burden of Proof -

The duty which falls on a party, usually the petitioner, of proving the contested allegations against a person in a court hearing.

Burn -

Tissue injury resulting from excessive exposure to thermal, chemical, electrical or radioactive agents. The effects vary according to the type, duration and intensity of the agent and part of the body involved. Burns are usually classified as follows:

First Degree - superficial with damage being limited to the outside of the skin.

Second Degree - the damage extends through the outer layer of the skin into the inner layer. Blistering will be present within two (2) hours.

Third Degree - the skin destroyed with damage extending into the underlying tissues, which may be charred or coagulated.

Capacity to Consent -
The mental ability to make a rational decision including the ability to perceive, appreciate all relevant facts and to reach a rational judgment based upon such facts.

Caregiver/Caretaker -
An individual or institution who is responsible for the day to day well being of another person as a result of family relationship, contract or agreement or who has assumed the responsibility for the care of the adult voluntarily and is perceived by the client to have a role in assisting the client with meeting his/her basic needs.

Clear and Convincing Evidence -
A level of proof which means the evidence clearly points to injury and to the perpetrator, but is not necessarily beyond a reasonable doubt.

Civil Proceeding -
Law suit that is not criminal in nature; a court action brought to enforce a right or obtain remuneration or compensation for a wrong as opposed to government action brought to punish a person for committing a crime.

Coercion -
Arbitrary, illegitimate use of power to achieve one's will (or a group's will) as by force or threat of force.

Collateral -
Contact with another person who can provide evidence or supportive testimony, but who is not a subject of the report.

Collateral Contact -
Contact with an individual other than the client who has knowledge of the situation and is a source of information for decision making.

Commitment -
A procedure by which a court orders a person to involuntarily undergo evaluation, treatment and rehabilitation for mental illness.

Competency -
The ability to care for oneself and manage one's property and financial affairs. An adult is presumed competent unless a court has found him/her incompetent and has appointed a guardian to act on his/her behalf.

Confabulation -
The falsification of memory in which gaps in recall are filled by fabrication which the person accepts as fact. Through generally a neurologic deficit, it may be an unconscious attempt to conceal embarrassment for memory loss or confusion. Confabulation occurs most frequently in organic mental disorders resulting from alcoholism, dementia, head injuries and lead poisoning.

Congregate Meals -
Meals served in a central dining area and in a manner designed to maximize social interaction and use of language skills.

Conservator -
A person who is legally responsible for the care and management of the person and/or property of an adult who is considered by law to be incapacitated.

Court Order -
Directive issued by the court having the authority of the court and enforceable by law through the court's contempt power; written command or directive given by a judge.

Court Ordered EMERGENCY Protective Services -
Services ordered by the court which may include removal of an elderly or disabled person to safer surroundings, authorization of medical treatment or other services necessary to reduce imminent danger of death when an individual lacks the capacity to consent to services.

Court Ordered Protective Services -
Services ordered by the court (usually in-home services) when the client lacks the capacity to consent and is at risk, but is not in imminent danger of death.

Credible Evidence -
Evidence worthy of belief by a reasonable person.

Custody -
The right of the Department or other person or entity responsible for the adult's welfare, to order the transport to and/or retention of the adult in such a location, e.g. hospital or nursing home, and to consent to the provision of any protective services ordered by the court to prevent the imminent "danger" to the adult.

Death -
Permanent cessation of all vital functions.

Decubitus -
A bed sore or ulcer normally caused by lying in one position for lengthy periods of time causing skin breakdown. In most severe stages can be life-threatening.

Dehydration -
The loss of water or fluid; especially an abnormal depletion of body fluids.

Delirium -
Decreased functioning of memory and other mental abilities because of temporary damage to the brain such as from trauma, infections, drug side effects or nutritional deficiencies.

Dementia -
Decreased functioning of memory and other mental abilities because of permanent damage to the brain. The onset and progression are usually gradual except in multi-infarct dementia (caused by repeated small strokes) where change can be sudden and remain at a plateau until the next sudden change. Unlike delirium, there is no improvement in mental abilities.

Department -
The Tennessee Department of Human Services.

Depression -
The most frequent emotional problem among the functional and organic mental disorders affecting the elderly. It is an emotional (affective) mood of pronounced sadness and misery.

Developmental Disability -
Severe chronic mental and/or physical impairment that occurs before the age of 22, is likely to continue indefinitely and limits 3 or more life activities, i.e., self-care, self-direction, learning, language, mobility, capacity for independent living and economic self-sufficiency.

Distractibility -
The inability to maintain attention on one topic; shifting from one area to another with little provocation. May be due to organic impairment (dementia) or other disorders such as anxiety, mania or schizophrenia.

District Attorneys -
Attorneys elected to represent the State of Tennessee in criminal and civil matters under their jurisdiction in the counties composing their districts which are established by law.

District Legal Counsel (DHS) -
Staff attorneys employed by the Department of Human Services to represent the county and district staff in court.

Documentation -
The adult protective services record created as a result of the investigation; also, records obtained from another source as supportive evidence.

Dual Diagnosis -
A diagnosis of both mental illness and developmental disability.

Durable Power of Attorney for Health Care -
A document in which an agent is appointed (sometimes called a proxy, surrogate or attorney-in-fact) to make health care decisions on behalf of an individual, should they become unable to make their own medical decisions. Often used in conjunction with a “Living Will”.

Emergency -
An immediate threat to life, health or property, requiring an immediate or same day response from the Adult Protective Services Counselor.

Emergency Order -
A court order which may give the Department the authority to consent to medical examinations, treatment and/or placement of an adult to prevent imminent danger or for protection from abuse or neglect to prevent imminent danger.

Emotional Abuse -
Impairment to the intellectual or psychological capacity of an individual's ability to function within a normal range of performance and behavior, with due regard to his/her culture and age.

Ex Parte -
One sided. A legal term to indicate the filing of a petition and the granting of an order during which the court will not hear testimony from the opposing side. Usually used in an emergency situation when the client cannot be present (hospitalized, comatose, etc.). Generally, a hearing on the order granted by this procedure must be held very soon after it is granted to give the party against whom it is granted the opportunity to contest the order.

Exploitation -
The improper use by a caretaker of funds which have been paid by a government agency to an adult or to the caretaker for the use or care of the adult.

Facility -
Any public or private hospital, nursing home, training center, clinic, school, which provides 24 hour programs or services for aged or disabled adults.

Fraud -
A deliberate misrepresentation or intentional concealment of information to receive funds or services or to be reimbursed for the delivery of services to which the individual is not entitled.

Guardian -
A person who is legally responsible for the care and management of a minor.

Hallucination -
Seeing, hearing, smelling, tasting, feeling things that are not really there. Auditory hallucinations, hearing voices outside the head are most common.

Home Delivered Meals -
Hot, nutritious meals purchased through contract from another agency and delivered to the home of the client on a regular basis.

Home Health Agency -
An organization that offers health care services in the client's home.

Imminent Danger -
Used in 1995 amendments to the Adult Protection Act. Defined as:

Conditions calculated to and capable of producing within a relatively short period of
time a reasonably strong probability of resultant irreparable physical or mental harm and/or the cessation of life if such conditions are not removed or alleviated. T.C.A. 71-6-102(9)

Imminent Danger of Death -
Conditions calculated to and capable of producing, within a relatively short period of time, a reasonably strong probability of resultant cessation of life if such conditions are not removed or alleviated.

Inadequate Clothing -
Clothing is consistently dirty, torn, too small, too large, worn thin or is not suitable for weather conditions.

Inadequate Food -
Failure to provide or to receive food necessary to sustain normal functioning or to prevent physical injury or to maintain life including failure to receive appropriate food for persons with conditions requiring special diets.

Inadequate Shelter -
May be shelter which is not structurally safe; has rodent or other infestations which may cause serious health problems; may not have a safe or accessible water supply, heat source or sewage disposal. The person must be protected from the elements which would seriously endanger his/her own health and result in serious illness or debilitating conditions.

Incontinence -
Inability to control bladder or bowel functions.

Information and Referral -
The process of sharing information or connecting individuals with specific needs to resources designed to meet those needs.

In-Home Services -
Services provided to clients in their own homes (homemaker, home health, home-delivered-meals, etc.).

Injunction -
A court order secured by DHS to enjoin an individual or individuals from interfering with the delivery of voluntary protective services to an aged or disabled adult, or from providing care to vulnerable adults where the person has been found to have abused, neglected or exploited the adult victim.

Institution -
A nursing home, state school or state hospital. Institutions are generally considered the most restrictive forms of alternative care.

Intake -
Process of taking a referral of alleged abuse, neglect or exploitation of an elderly or disabled individual.

Intermediate Care Facility -
Since 10/1/90, ICF Services only applies to Mental Retardation facilities. They provide inpatient care for people who require skilled nursing supervision and supportive care but who do not need continuous nursing care.

Internal Injuries -
Injuries not visible from the outside, an injury to the organs occupying the thoracic, abdominal or cranial cavities and can be the result of a direct blow. A person so injured may be pale, cold, perspiring freely, have an anxious expression, may seem semicomatose. Pain, usually intense at first, may continue or gradually diminish as patient grows worse.

Intervention -
The process of involving oneself in the affairs of another. The purpose of social work intervention is to assist an individual or family to improve conditions of health, safety, personal care and/or facilitate more satisfying interpersonal relationships.

Investigation -
A fact finding process which includes, but is not limited to, a personal interview with the individual alleged to be abused, neglected or exploited. In addition, contacts should be made with collateral sources in an effort to determine the validity of the report received. Records and evaluations from appropriate professionals, agencies, etc. are obtained.

Law Enforcement -
Personnel designated to maintain law and order in a given geographical division.

Least Restrictive Alternative -
An alternative that permits maximum self determination while meeting the needs of the client.

Liability -
The state of being responsible for certain actions; having a duty enforceable by law.

Licensed Facility -
A facility which meets standards set by a regulatory body which has legal responsibility to evaluate quality of services provided.

Malnutrition/Starvation -
Lack of nutrition; inadequate or unbalanced nutrition. Requires a medical Diagnosis.

Mandated Reporter -
Any person who knows or has reason to suspect that an adult has suffered abuse, neglect or exploitation is required, by law, to report or cause a report to be made to the Tennessee Department of Human Services.

Medical Neglect -
Failure to seek medical or dental treatment for a health problem or condition which, if untreated, could become severe enough to represent a danger for an aged or disabled adult.

Mental Illness -
Illness, disease, or condition which either: substantially impairs the person's thought, perception of reality, emotional process or judgment or grossly impairs behavior as manifested by recent disturbed behavior.

Mental Retardation -
Subaverage general intellectual functioning with deficits in adaptive behavior as determined by a comprehensive diagnosis and evaluation.

Misdemeanor -
A category of crime, for which the authorized punishment is less than one year and/or a fine of $2,500.00.

Neglect -
Deprivation of services by a caretaker which are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain for one's self the services which are necessary to maintain his/her own health and welfare.

Negligence -
The act of disregarding or ignoring, failure to care for or give proper attention to.

Nervous Breakdown -
A nonmedical and nonspecific description commonly used for any type of mental distress or disorder.

Nursing Facilities -
Inpatient health care facilities that provide nursing and personal care over an extended period of time (usually more than 30 days) for people who require convalescent care at a level which is less than that provided in an acute care facility and/or for chronically ill, aged or disabled individuals. Since 10/1/90 ` replaced Skilled Nursing Facility and Intermediate Care Facility (except for Mental Retardation ICF's).

Ombudsman -
One who investigates and resolves complaints of residents or families of residents in long term care residential facilities.

Ongoing Protective Services -
Activities arranged for or performed by the counselor to help a client needing protective services.

Paranoid Ideation -
Unwarranted suspicion or belief that one is being harmed.

Perpetrator -
The descriptive term for the person who is responsible for the abuse, neglect or exploitation of an aged or disabled person.

Petition -
A written request filed with a court asking that it take action in a particular case.

Phobia -
An irrational fear with a persistent, compelling desire to avoid the dreaded object.

Power of Attorney -
A document executed by one person giving another the right and authority to act for him/her in a specific situation. It is automatically terminated on the death of the grantor or if the grantor is judged incompetent. It does not revoke the power of attorney in situations in which the attorney in fact, without actual knowledge of the disability or incapacity acts in "good faith" under the power. See Section T.C.A. 34-6-105

Preponderance of Evidence -
A level of proof which means that it is more likely than not that something occurred.

Probable Cause -
The facts are such as to make a reasonable person believe that it is more likely than not that the alleged situation or circumstances are true.

Protective Services -
Services undertaken by the Department with or on behalf of an adult in need of protection from abuse, neglect or exploitation.

Psychosis -
A major mental disorder of organic or emotional origin in which a person's ability to think, respond emotionally, remember, communicate, interpret reality and behave appropriately is grossly impaired and interferes with their capacity to meet the ordinary demands of life.

Reasonable Cause to Suspect -
Evidence which would lead a reasonable person to suspect that abuse, neglect or exploitation has occurred.

Referral -
An oral or written allegation identifying an elderly or disabled adult as the suspected victim of abuse, neglect or exploitation.

Referent -
The entity (individual, program or agency) that conveys information (makes a referral or report) to the Department regarding the possible abuse, neglect, or exploitation of an elderly or disabled adult. The identity of the referent is kept confidential.

Report -
Written or oral conveyance of a person's reasonable suspicions that an elderly or disabled adult is being abused, neglect or exploited.

Reporter -
The individual who makes the initial referral on situations of alleged abuse, neglect, or exploitation of an elderly or disabled adult.

Representative Payee -
An individual appointed by a government agency to receive funds on behalf of a beneficiary who is unable to manage his/her own finances.

Scalding -
A burn to the skin or flesh caused by moist heat and hot vapors, as steam. A scald is deeper than a burn from dry heat and should be treated as a burn.

Search Warrant -
Used when APS staff need to gain entry or access to the adult in order to proceed with the investigation. Probable cause that an adult is being abused, neglected, or exploited must be shown.

Self-Determination -
Free choice of one's own acts and circumstances without external compulsion.

Self-Sufficiency -
A situation in which a person is able to maintain his/her home in a safe and hazard free condition, is able to maintain his/her nutritional, medical, physical and personal care needs and is able to access community resources.

Sexual Abuse -
Occurs when an impaired adult is forced tricked, threatened or otherwise coerced into sexual contact against his/her will or when the impaired adult lacks the judgment or capacity to consent to sexual contact. This unwanted sexual contact may include physical and emotional abuse and verbal harassment of a sexual nature. Sexual contact may be abusive even if the perpetrator is the spouse or partner of the victim.

Skilled Care Facility -
See Nursing Facilities.

Skull Fracture -
A broken bone in the skull.

Stressors -
Threatening, challenging or harmful stimuli that create tension for the individual and require extra energy to cope.

Substantial and Material Evidence -
Such relevant evidence as a reasonable mind might accept to support a rational conclusion and such as to furnish a reasonably sound basis for the action under consideration. (Southern RY. CO. v. State BD. of Equalization cite as 682 S.W. 2d 196 Tenn. 1984)

Supplemental Security Income (SSI) -
Monthly payments made by the Social Security Administration to an elderly or disabled individual who meets the requirements for public aid. Social Security determines eligibility for SSI.

Temporary Guardian -

Granted for a person assigned by the court to manage the resources/finances of an incapacitated adult for up to six months. Only used in conjunction with a custody order granted to DHS. DHS does not manage a client's finances. T.C.A. 74-6-107(a)(6)

Thought Disorder -

A disruption in a person's ability to think clearly, both in terms of what they think about and how they think about it. A thought disorder can be caused by either a functional emotional disturbance (schizophrenia) or by an organic condition (dementia).

Victim -

A person who is made to suffer by the act of himself or another person or by the failure of himself or another person to act in his behalf.

APPENDIX 11-01

TENNESSEE ADULT PROTECTION ACT

Programs and Services for Abused Persons
T.C.A. 71-6-101 - 71-6-122

As Amended in 1980, 1986,1989, 1995, 1996, 1999, 2000, 2001, 2003, and 2004

TENNESSEE ADULT PROTECTION ACT

TCA CHAPTER 6 -- PROGRAMS AND SERVICES FOR ABUSED PERSONS

Part 1 - Adult Protection

1978 As Amended in 1980, 1986,1989, 1995, 1996, 1999, 2000, 2001, 2003, and 2004
(1974, Tennessee Protective Services for Elderly Persons Act, was Repealed in 1978)

SECTION.

71-6-101. Short title -- Legislative intent.
71-6-102. Definitions.
71-6-103. Rules and regulations -- Reports of abuse or neglect -- Investigation -- Providing protective services -- Consent of adult -- Duties of other agencies.
71-6-104. Remedies -- Injunctive relief.
71-6-105. Reporting or investigating parties -- Immunity from liability -- Protection from job discrimination.
71-6-106. Privilege for confidential communications.
71-6-107. Provision of protective services without the consent of the adult.
71-6-108. Prohibitions.
71-6-109. Payment for protective services.
71-6-110. Violation of duty to report.
71-6-111. Authority and responsibility of department.
71-6-112. Funding.
71-6-113. Cooperation by other departments -- Specialized care.
71-6-114. Jurisdiction and venue.
71-6-115. Cooperation by law enforcement officials.
71-6-116. Motion for review of court decree.
71-6-117. Willful abuse, neglect or exploitation prohibited -- Penalty.
71-6-118. Confidentiality of information, reports and proceedings -- Penalties.
71-6-119. Willful physical abuse or gross negligence -- Penalties.
71-6-120. Right of elderly person or disabled adult to recover for abuse or neglect, sexual abuse or exploitation, or theft.
71-6-121. Contact information for advanced-age victims of abuse, neglect, and exploitation; posting requirements; exemption --
71-6-122. Telephone service to report abuse, neglect, and exploitation--

71-6-101. Short title --- Legislative intent. --- (a) This part may be cited as the "Tennessee Adult Protection Act."

(b)(1) The purpose of this part is to protect adults coming within the provisions of the part from abuse, neglect or exploitation by requiring reporting of suspected cases by any person having cause to believe that such cases exist. It is intended that, as a result of such reports, the protective services of the state shall prevent further abuse, neglect or exploitation within the limitations set out in this part.

(2) It is recognized that adequate protection of adults will require the cooperation of many agencies and service providers in conjunction with the department of human services due to the often complex nature of the risks to this adult group, and that services to meet the needs of this group will not always be available in each community. However, it is desirable that the following services, as well as other services needed to meet the intent of this part, be available: medical care, mental health and mental retardation services, including in-home assessments and evaluations; in-home services including homemaker, home-health, chore, meals; emergency services including shelter; financial assistance; legal services; transportation; counseling; foster care; day-care; respite care; and other services as needed to carry out the intent of this part. [Acts 1978, ch. 899, § 1; T.C.A., § 14-2601; Acts 1986, ch. 630, § 1; T.C.A., § 14-25-101.]

71-6-102. Definitions. --- As used in this part, unless the context otherwise requires:

(1) "Abuse or neglect" means the infliction of physical pain, injury, or mental anguish, or the deprivation of services by a caretaker which are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain the services which are necessary to maintain that person's health or welfare. Nothing in this part shall be construed to mean a person is abused or neglected or in need of protective services for the sole reason that the person relies on or is being furnished treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment; further, nothing in this part shall be construed to require or authorize the provision of medical care to any terminally ill person if such person has executed an unrevoked living will in accordance with the provisions of the Tennessee Right to Natural Death Law, compiled in title 32, chapter 11, and if the provisions of such medical care would conflict with the terms of such living will;

(2) "Adult" means a person eighteen (18) years of age or older who because of mental or physical dysfunctioning or advanced age is unable to manage such person's own resources, carry out the activities of daily living, or protect such person from neglect, hazardous or abusive situations without assistance from others and who has no available, willing, and responsibly able person for assistance and who may be in need of protective services;

(3) "Advanced age" means sixty (60) years of age or older;

(4) "Capacity to consent" means the mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts. A decision itself to refuse services cannot be the sole evidence for finding the person lacks capacity to consent;

(5) "Caretaker" means an individual or institution who has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult person voluntarily, or by contract, or agreement;

(6) "Commissioner" means the commissioner of human services;

(7) "Department" means the department of human services;

(8) "Exploitation" means the improper use by a caretaker of funds which have been paid by a governmental agency to an adult or to the caretaker for the use or care of the adult;

(9) "Imminent danger" means conditions calculated to and capable of producing within a relatively short period of time a reasonably strong probability of resultant irreparable physical or mental harm and/or the cessation of life if such conditions are not removed or alleviated. However, the department is not required to assume responsibility for a person in imminent danger pursuant to this chapter except when, in the department's determination, sufficient resources exist for the implementation of this part.

(10) "Investigation" includes, but is not limited to, a personal interview with the individual reported to be abused, neglected, or exploited. When abuse or neglect is allegedly the cause of death, a coroner's or doctor's report shall be examined as part of the investigation;

(11) "Protective services" means services undertaken by the department with or on behalf of an adult in need of protective services who is being abused, neglected, or exploited. These services may include, but are not limited to, conducting investigations of complaints of possible abuse, neglect, or exploitation to ascertain whether or not the situation and condition of the adult in need of protective services warrants further action; social services aimed at preventing and remedying abuse, neglect, and exploitation; services directed toward seeking legal determination of whether the adult in need of protective services has been abused, neglected or exploited and procurement of suitable care in or out of the adult's home; and

(12) "Sexual abuse" occurs when an adult, as defined in this chapter, is forced, tricked, threatened or otherwise coerced by a person into sexual activity, involuntary exposure to sexually explicit material or language, or sexual contact against such adult's will. Sexual abuse also occurs when an "adult," as defined in this chapter, is unable to give consent to such sexual activities or contact and is engaged in such activities or contact with another person. [Acts 1978, ch. 899, § 1; T.C.A., § 14-2602; 1980, ch. 513, § 2; 1986, ch. 630, §§ 2, 3; T.C.A., § 14-25-102; Acts 1995, ch. 486, §§ 1, 2, 9, 17; 1996, ch. 1029, § 1.]

71-6-103. Rules and regulations --- Reports of abuse or neglect --- Investigation --- Providing protective services --- Consent of adult --- Duties of other agencies. --- (a) The commissioner has the discretion to adopt such rules, regulations, procedures, guidelines, or any other expressions of policy necessary to effect the purpose of this part insofar as such action is reasonably calculated to serve the public interest.

(b)(1) Any person, including, but not limited to, a physician, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this part. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death. However, unless the report indicates that there are other adults in the same or similar situation and that an investigation and provision of protective services are necessary to prevent their possible abuse, neglect or exploitation, it shall not be necessary for the department to make an investigation of the circumstances surrounding the death; provided, that the appropriate law-enforcement agency is notified.

(2) If a hospital, clinic, school, or any other organization or agency responsible for the care of adults has a specific procedure, approved by the director of the county office of the department, for the protection of adults who are victims of abuse, neglect, or exploitation, any member of its staff whose duty to report under the provisions of this part arises from the performance of the staff member's services as a member of the staff of the organization may, at the staff member's option, fulfill that duty by reporting instead to the person in charge of the organization or the organization head's designee who shall make the report in accordance with the provisions of this chapter.

(c) An oral or written report shall be made immediately to the department upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: the name and address of the adult, or of any other person responsible for the adult's care; the age of the adult; the nature and extent of the abuse, neglect, or exploitation, including any evidence of previous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation. Each report of known or suspected abuse of an adult involving a sexual offense which is a violation of §§ 39-13-501 --- 39-13-506 which occurs in a facility licensed by the department of mental health and developmental disabilities as defined in § 33-2-402, or any hospital shall also be made to the local law enforcement agency in the jurisdiction where such offense occurred.

(d) Upon receipt of the report, the department shall take the following action as soon as practical:

(1) Notify the appropriate law enforcement agency in all cases in which the report involves abuse, neglect, or exploitation of the adult by another person or persons;

(2) Notify the appropriate licensing authority if the report concerns an adult who is a resident of, or at the time of any alleged harm is receiving services from, a facility that is required by law to be licensed or the person alleged to have caused or permitted the harm is licensed under title 63. The commissioner of health, upon becoming aware through personal knowledge, receipt of a report or otherwise, of confirmed exploitation, abuse, or neglect of a nursing home resident, shall report such instances to the Tennessee bureau of investigation for a determination by the bureau as to whether the circumstances reported constitute abuse of the Medicaid program or other criminal violation;

(3) Initiate an investigation of the complaint;

(4) Make a written report of the initial findings together with a recommendation for further action, if indicated; and

(5) After completing the evaluation, the department shall notify the person making the report of its determination.

(e) Any representative of the department may enter any health facility or health service licensed by the state at any reasonable time to carry out its responsibilities under this part.

(f) Any representative of the department may, with consent of the adult or caretaker, enter any private premises where any adult alleged to be abused, neglected, or exploited is found in order to investigate the need for protective services for the purpose of carrying out the provisions of this part. If the adult or caretaker does not consent to the investigation, a search warrant may issue upon a showing of probable cause that an adult is being abused, neglected, or exploited, to enable a representative of the department to proceed with the investigation.

(g) If a determination has been made that protective services are necessary when indicated by the investigation, the department shall provide such services within budgetary limitations, except in such cases where an adult chooses to refuse such services.

(h) In the event the adult elects to accept the protective services to be provided by the department, the caretaker shall not interfere with the department when rendering such services.

(i) If the adult does not consent to the receipt of protective services, or if the adult withdraws consent, the services shall be terminated, unless the department determines that the adult lacks capacity to consent, in which case it may seek court authorization to provide protective services.

(j)(1) Any representative of the department actively involved in the conduct of an abuse, neglect, or exploitation investigation under this part shall be allowed access to the mental and physical health records of the adult which are in the possession of any individual, hospital, or other facility if necessary to complete the investigation mandated by this chapter.

(2) To complete the investigation required by this part, any authorized representative of the department actively involved in the conduct of an investigation pursuant to this part shall be allowed access to any law enforcement records or personnel records, not otherwise specifically protected by statute, of any person who is:

(A) A caretaker of the adult, or

(B) The alleged perpetrator of abuse, neglect or exploitation of the adult, who is the subject of the investigation.

(3)(A) If refused any information pursuant to subdivisions (j)(1) and (2), any information from any records necessary for conducting investigations pursuant to this part may be obtained upon motion by the department to the circuit, chancery or general sessions court of the county where such records are located, or in the court in which any proceeding concerning the adult may have been initiated or in the court in the county in which the investigation is being conducted.

(B) The order on the department's motion may be entered ex parte upon a showing by the department of an immediate need for such information.

(C) The court may enter such orders as may be necessary to ensure that the information sought is maintained pending any hearing on the motion, and to protect the information obtained from further disclosure if the information is made available to the department pursuant to the court's order.

(4)(A) The department may be allowed access to financial records that are contained in any financial institution, as defined by § 45-10-102(3) regarding:

(i) The person who is the subject of the investigation;

(ii) Any caretaker of such person; and

(iii) Any alleged perpetrator of the abuse, neglect or exploitation of such person;

(B) By the issuance of an administrative subpoena in the name of the commissioner or an authorized representative of the commissioner which is:

(i) Directed to the financial institution, and

(ii) Which complies with the provisions of §§ 45-10-106 and 45-10-107; or

(C) By application, as otherwise required pursuant to § 45-10-117, to the circuit or chancery court in the county in which the financial institution is located, or in the court in which any proceeding concerning the adult may have been initiated or in which the investigation is being conducted, for the issuance of a judicial subpoena that complies with the requirement of § 45-10-107; provided that the department shall not be required to post a bond pursuant to § 45-10-107(4).

(D) Nothing in this subdivision shall be construed to supersede the provision of financial records pursuant to the permissible acts allowed pursuant to § 45-10-103.

(5) Any records received by the department, the confidentiality of which is protected by any other statute or regulation, shall be maintained as confidential pursuant to the provisions of such statutes or regulations, except for such use as may be necessary in the conduct of any proceedings pursuant to its authority pursuant to this part or title 33 or 34.

(k)(1) If, as a result of its investigation, the department determines that an adult who is a resident or patient of a facility owned or operated by an administrative department of the state is in need of protective services, and the facility is unable or unwilling to take action to protect the resident or patient, the department shall make a report of its investigation, along with any recommendations for needed services to the commissioner of the department having responsibility for the facility. It shall then be the responsibility of the commissioner for that department and not the department of human services to take such steps as may be necessary to protect the adult from abuse, neglect, or exploitation and, in such cases, the affected administrative department of the state shall have standing to petition the court.

(2) Notwithstanding any other provisions of subdivision (k)(1) or this part to the contrary, the department of human services shall not be required to investigate, and the department of mental health and developmental disabilities shall not be required to report to the department of human services, any allegations of abuse, neglect or exploitation involving an individual that arise from conduct occurring in any institutions operated directly by the department of mental health and developmental disabilities. Allegations of abuse, neglect or exploitation of individuals occurring in such institutions shall be investigated by investigators of the department of mental health and developmental disabilities who have been assigned to investigate such allegations.

(l) In the event the department, in the course of its investigation, is unable to determine to its satisfaction that sufficient information is available to determine whether an adult is in imminent danger or lacks the capacity to consent to protective services, an order may be issued, upon a showing of probable cause that an adult lacks capacity to consent to protective services and is being abused, neglected, or exploited, to require the adult to be examined by a physician, a psychologist in consultation with a physician or a psychiatrist in order that such determination can be made. An order for examination may be issued ex parte upon affidavit or sworn testimony if the court finds that there is cause to believe that the adult may be in imminent danger and that delay for a hearing would be likely to substantially increase the adult's likelihood of irreparable physical or mental harm, or both, and/or the cessation of life. [Acts 1978, ch. 899, § 1; T.C.A., §14-2603; Acts 1980, ch. 513, §§ 3-5, 8; 1986, ch. 630, §§ 5-8; T.C.A., § 14-25-103; Acts 1993, ch. 439, § 3; 1995, ch. 486, §§ 2, 14; 1999, ch. 247, § 2, 2000, ch. 947 §§ 6, 8M; 2001, ch. 204, §§ 1, 2.]

71-6-104. Remedies --- Injunctive relief. --- (a) Any court with jurisdiction under this part may upon proper application by the department issue a temporary restraining order or other injunctive relief to prohibit any violation of this part, regardless of the existence of any other remedy at law.

(b) The court may enjoin from providing care for any person, on a temporary or permanent basis, any employee or volunteer, who the court finds has engaged in the abuse, neglect or exploitation of an adult as defined in the part, in any situation involving the care of such adult by such employee or volunteer, whether such actions occurred in an institutional setting, in any type of group home or foster care arrangement serving adults, and regardless of whether such person, facility or arrangement serving adults is licensed to provide care for adults. [Acts 1978, ch. 899, § 1; T.C.A., § 14-2604; Acts 1986, ch. 630, §18; T.C.A., § 14-25-104; Acts 1995, ch. 486, § 8.]

71-6-105. Reporting or investigating parties --- Immunity from liability --- Protection from job discrimination. --- Any person making any report or investigation pursuant to this part, including representatives of the department in the reasonable performance of their duties and within the scope of their authority, shall be presumed to be acting in good faith and shall thereby be immune from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report or investigation. Any person making a report under the provisions of this part shall have a civil cause of action for appropriate compensatory and punitive damages against any person who causes a detrimental change in the employment status of the reporting party by reason of the report. [Acts 1978, ch. 899, § 1; T.C.A., § 14-2605; Acts 1980, ch. 513, § 6; T.C.A., § 14-25-105.]

71-6-106. Privilege for confidential communications. --- Notwithstanding the existence of the privilege for confidential communications between husband and wife, the chancellor at the hearing may compel testimony if, in the chancellor's opinion, disclosure is necessary in the interest of the adult. [Acts 1978, ch. 899, § 1; T.C.A., §§ 14-2606, 14-25-106.]

71-6-107. Provision of protective services without the consent of the adult. --- (a)(1)(A) If the department determines that an adult who is in need of protective services is in imminent danger if that adult does not receive protective services and lacks capacity to consent to protective services, then the department may file a complaint with the court for an order authorizing the provision of protective services necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life. The judge or chancellor shall hear the complaint ahead of any other business then pending in court or in chambers. This order may include the designation of an individual or organization to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf. The complaint must allege specific facts sufficient to show that the adult is in imminent danger if the adult does not receive protective services and lacks capacity to consent to protective services. Prior to filing a complaint with the court for an order authorizing removal of an adult from that adult's chosen place of residence, the department shall make reasonable efforts to exhaust all practical alternatives to the removal of such adult from such place of residence.

(B) In situations where the department must present a petition for emergency removal of an adult in imminent danger and a chancellor or circuit judge is unavailable, the department may present petitions to judicial officers with general sessions jurisdiction. Further proceedings shall be conducted in chancery or circuit court.

(C) For the purpose of this section, "sexual abuse," as defined in this chapter, shall provide grounds for the department to obtain custody of an adult who lacks capacity to consent when such abuse relates to sexual activity or contact.

(2) The judge or chancellor or the general sessions court judge, prior to entering the order, must find that the adult is in imminent danger if the adult does not receive protective services and lacks capacity to consent to protective services.

(3) Within seven (7) days of entering an order pursuant to this section, or for good cause shown, then up to fifteen (15) days, the court shall hold a hearing on the merits. If such a hearing is not held within such time, the order authorizing the provision of protective services shall be dissolved.

(4) The adult must receive at least forty-eight (48) hours notice of the hearing, unless for good cause shown, a shorter time is allowed by the court. The adult has a right to be present and represented by counsel at the hearing. If the adult is indigent or, in the determination of the judge or chancellor, lacks capacity to waive the right to counsel, then the court shall appoint counsel. If the adult is indigent, court costs and the cost of representation shall be borne by the state; otherwise such costs shall be borne by the adult.

(5)(A) Protective services necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life authorized by order pursuant to this section may include, but are not limited to, taking the adult into physical custody in the home, a medical or nursing care facility, or, if available, an alternative living arrangement exclusive of a developmental center operated by the department of mental health and developmental disabilities; provided, that the court finds that such custody is for the purpose of medical examination and treatment necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life or protection from abuse or neglect necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life, and that the court specifically authorizes such custody in its order. In determining what specific custodial authority to grant under this section, the court shall consider whether the imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life is relatively mild or severe and authorize such custody as is appropriate under the circumstances. The department shall review the decree at least annually to determine whether the prerequisites for custody still exist.

(B) Within a reasonable period of time after an adult is taken into physical custody and placed other than in a medical or nursing care facility, the department shall cause an appropriate examination to be made of the adult to determine the cause or causes resulting in the adult's lack of capacity to consent, if such determination had not been made at the time of the final hearing.

(6) In the event that the adult has sufficient resources to defray the costs of a medical or nursing care facility, or an appropriate alternative living arrangement, as decreed by the court pursuant to this subsection, and that without such resources the adult would be unable to enter such facility or alternative living arrangement, then the court may appoint a temporary guardian for such period as necessary to secure and disburse the adult's resources for that purpose, but for no longer than six (6) months from the entry of the order authorizing provision of protective services. However, the court in its discretion may extend such period for a period no longer than an additional six (6) months. The guardian appointed pursuant hereto shall file an accounting with the court as to the resources used.

(7) If the department refuses to exercise the powers granted to it by subdivision (a)(1), any private non-profit agency representing disabled adults may proceed under subdivision (1), after giving notice to the department of intent to do so. If an order authorizing the provision of protective services results, the department's responsibilities are the same as they would have been if the department had sought the order. If the court finds that an order authorizing the provision of protected services is not warranted, any agency proceeding under this subdivision will be responsible for the cost of the court-appointed attorney representing the individual for whom protective services were sought as well as court costs.

(b)(1) If the department determines that an adult is in need of protective services and lacks capacity to consent to protective services, then the department may petition the judge or chancellor for a hearing. The complaint must allege specific facts sufficient to show that the adult is in need of protective services and lacks capacity to consent to protective services.

(2) The adult must receive at least ten (10) days notice of the hearing. The adult has a right to be present and represented by counsel at the hearing. If the adult is indigent or, in the determination of the judge or chancellor, lacks capacity to waive the right to counsel, then the court shall appoint counsel. If the adult is indigent, court costs and the cost of representation shall be borne by the state; otherwise such costs shall be borne by the adult.

(3) If the judge or chancellor finds that the adult is in need of protective services and lacks capacity to consent to protective services, then the judge or chancellor may enter a decree authorizing the provision of protective services. This decree may include the designation of an individual or organization to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf.

(c) An individual or organization appointed pursuant to subsection (a) or (b) to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf or to serve as temporary guardian shall have only specific authority as the court shall provide in its order. Such authority shall be limited to the authority to consent to specified protective services, including medical care if ordered, and if ordered pursuant to subsection (a), may arrange for, and consent to, appropriate custodial care and gain access to and disburse the adult's resources. If the adult is in need of a person to manage the adult's affairs or to have other responsibilities not addressed herein, the procedures and requirements for appointment of a conservator pursuant to title 34, chapter 11 or 13, must be followed. Nothing in this section shall be construed as requiring the department to initiate proceedings for the appointment of a conservator or a temporary guardian or to accept such appointment if proceedings are instituted or to initiate proceedings under title 34, chapter 11 or 13. [Acts 1978, ch. 899, § 1; T.C.A., § 14-2607; Acts 1980, ch. 513, § 7; 1986, ch. 630, §§ 9-14; 1986, ch. 892, § 1; T.C.A., § 14-25-107; 1995, ch. 486, §§ 2-5, 7, 10-13, 15, 19; 1999, ch.247, § 3; 2000, ch. 947, § 6.]

71-6-108. Prohibitions. --- No adult may be adjudicated incompetent or committed to a mental institution under this chapter. [Acts 1978, ch. 899, § 1; T.C.A., §§ 14-2608, 14-25-108.]

71-6-109. Payment for protective services. --- If the department determines that the adult is financially capable of paying for the protective services received, according to standards to be set by the department, the adult shall reimburse the state for the cost of providing the protective services. If the department determines that the adult is not financially capable of paying for the protective services received, the state shall bear the cost of providing the protective services. Otherwise, the department may recover such cost from the adult in any court of competent jurisdiction. [Acts 1978, ch. 899, § 1; T.C.A., §§ 14-2609, 14-25-109.]

71-6-110. Violation of duty to report. --- Any person who knowingly fails to make a report required by this chapter commits a Class A misdemeanor. [Acts 1978, ch. 899, § 1; T.C.A., § 14-2610; Acts 1986, ch. 630, § 15; T.C.A., § 14-25-110; Acts 1989, ch. 591, § 111.]

71-6-111. Authority and responsibility of department. --- It is the legislative intent that the protective services set out hereinabove be provided and that the department have present authority to provide or to arrange for the provision of the same. However, the provision of the services is subject to budgetary limitations and the availability of funds appropriated for the general provision of protective services to all persons entitled thereto. [Acts 1978, ch. 899, § 1; T.C.A., §§ 14-2611, 14-25-111.]

71-6-112. Funding. --- The cost of the administration of this part and the provision of the services hereby authorized shall be limited to the amount of funds specifically appropriated for such purposes by the general assembly. [Acts 1978, ch. 899, § 1; T.C.A., §§ 14-2612, 14-25-112.]

71-6-113. Cooperation by other departments---Specialized care. --- (a) It is the legislative intent that the department of mental health and developmental disabilities and the department of health shall assist the department of human services in any way possible to provide the services required under this part.

(b) When the department of human services is unable to find a resource for any person in need of protective services who, because of mental illness or developmental disabilities, is in need of specialized care or treatment, the department of mental health and developmental disabilities shall give priority to such person for appropriate placement. [Acts 1978, ch. 899, § 2; T.C.A., § 14-2613; Acts 1986, ch. 630, § 16; T.C.A., § 14-25-113; Acts 2000, ch. 947, § 6.]

71-6-114. Jurisdiction and venue. --- (a) The circuit , general sessions, and chancery courts have jurisdiction of proceedings arising under this part. Probate courts in counties having a population of not less than seven hundred seventy-five thousand (775,000) according to the 1980 federal census or any subsequent federal census shall have concurrent jurisdiction with the circuit and chancery courts.

(b) A proceeding under this part may be commenced in the county where the adult resides or is physically present. [Acts 1986, ch. 630, § 4; T.C.A., § 14-25-114; 1995, ch. 486, § 16.]

71-6-115. Cooperation by law enforcement officials. --- It is the legislative intent that law enforcement officials shall cooperate with the department of human services in providing protective services under this part. Further, when the department is unable to return an adult to physical custody who voluntarily leaves such custody, law enforcement officials shall assist in returning the adult to such physical custody and shall give priority in providing such assistance. [Acts 1986, ch. 630, § 17; T.C.A., § 14-25-115.]

71-6-116. Motion for review of court decree. --- Either party to a proceeding under this part, or any interested person on behalf of the adult subject to such a proceeding, may file a motion for review of the decree of the court at any time. [Acts 1986, ch. 630, § 17; T.C.A., § 14-25-116.]

71-6-117. Willful abuse, neglect or exploitation prohibited---Penalty. --- It is unlawful for any person to willfully abuse, neglect or exploit any adult within the meaning of the provisions of this part. Any person who willfully abuses, neglects or exploits a person in violation of the provisions of this part commits a Class A misdemeanor. [Acts 1986, ch. 630, § 17; T.C.A., § 14-25-117; Acts 1989, ch. 591, § 111.]

71-6-118. Confidentiality of information, reports and proceedings --- Penalties. --- (a) The identity of a person who reports abuse, neglect, or exploitation as required under this part is confidential and may not be revealed unless a court with jurisdiction under this part so orders for good cause shown.

(b) Except as otherwise provided in this part, it is unlawful for any person, except for purposes directly connected with the administration of this part, to disclose, receive, make use of, authorize or knowingly permit, participate, or acquiesce in the use of any list or the name of, or any information concerning, persons receiving services pursuant to

this part, or any information concerning a report or investigation of a report of abuse, neglect, or exploitation under this part, directly or indirectly derived from the records, papers, files or communications of the department of human services or division thereof acquired in the course of the performance of official duties. When necessary to protect adults in a health care facility, such information, reports, and investigations may be disclosed to the department of health; however, such information, reports, and investigations shall retain the protections of this subsection when disclosed to the department of health and may not be disclosed to, or used by, any other person.

(c) A violation of any provision of this section is a Class B misdemeanor. [Acts 1986, ch. 630, § 17; T.C.A., § 14-25-118; Acts 1989, ch. 591, § 112.]

71-6-119. Willful physical abuse or gross negligence --- Penalties. --- Willful physical abuse or gross neglect of an impaired adult with resulting serious mental or physical harm shall be punishable as an aggravated assault. [Acts 1995, ch. 486, § 6.]

71-6-120. Right of elderly person or disabled adult to recover for abuse or neglect, sexual abuse or exploitation, or theft.--- (a) As used in this section, unless the context otherwise requires:

(1) "Capacity to consent" means the mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts; or to make and carry out reasonable decisions concerning the person or the person's resources; or to protect the person from neglect, or hazardous or abusive situations without assistance;

(2) "Disabled adult" means a person who is eighteen (18) years of age or older and who meets one (1) of the following:

(A) Has some impairment of body or mind that makes the person unfit to work at any substantially remunerative employment;

(B) Lacks the capacity to consent;

(C) Has been certified as permanently and totally disabled by an agency of this state or the United States that has the function of so classifying persons; or

(D) Has been found to be incompetent by a court of proper jurisdiction; and

(3) "Elderly person" or "elder" means a person who is sixty (60) years of age or older who has some mental or physical dysfunctioning, including any resulting from age.

(b) In addition to other remedies provided by law, an elderly person or disabled adult in that person's own right, or by conservator or next friend, shall have a right of recovery in a civil action for compensatory damages for abuse or neglect, sexual abuse or exploitation as defined in this part or for theft of such person's or adult's money or property whether by fraud, deceit, coercion or otherwise. Such right of action against a wrongdoer shall not abate or be extinguished by the death of the elderly person or disabled adult, but shall pass as provided in § 20-5-106, unless the alleged wrongdoer is a family member, in which case the cause of action shall pass to the victim's personal representative.

(c) Jurisdiction for such action shall be in the circuit or chancery court where the elderly person or disabled adult may reside or where the actions occurred.

(d) Damages shall include compensatory damages and costs where it is proven that a defendant is liable for abuse or neglect, sexual abuse or exploitation as defined in this part or for theft of such elderly person's or disabled adult's money or property whether by fraud, deceit, coercion or otherwise. Costs shall include reasonable expenses. In addition, if it is proven upon clear and convincing evidence that abuse or neglect, sexual abuse or exploitation or theft resulted from intentional, fraudulent or malicious conduct by the defendant, a claimant shall be entitled to recover reasonable

attorneys' fees. As part of any judgment, the court may declare void and unenforceable any marriage proven to have been entered into as part of a scheme to commit abuse or neglect, sexual abuse or exploitation as defined in this part or theft of such elderly person's or disabled adult's money or property whether by fraud, deceit, coercion or otherwise.

(e) In addition to the damages described in (d), a defendant may also be found liable for punitive damages in accordance with applicable common law standards.

(f) Nothing in this section shall be construed as requiring the department of human services to initiate any proceedings pursuant to this section or to act on behalf of any elderly person or disabled adult subject to this section.

(g) This section shall not apply to a cause of action within the scope of Title 29, Chapter 26, and such cause of action shall be governed solely by Title 29, Chapter 26. [Acts 1999, ch. 247, § 1; 2000, ch. 768, §§ 1-3.]

(h) A financial institution, officer, director, or employee thereof, shall not be liable in any civil action brought by or on behalf of a disabled adult or elderly person for recovery of damages under this chapter, unless prior to such civil action, the financial institution, officer, director, or employee thereof, shall have been convicted of a violation of T.C.A. § 71-6-117. Provided, however, this provision shall not apply to theft or conversion by an employee, officer or director of a financial institution or liability arising under other provisions of law.

71-6-121. Contact information for advanced-age victims of abuse, neglect, and exploitation; posting requirements; exemption -- (a) All offices of physicians licensed pursuant to title 63, chapter 6 or 9, all health care facilities licensed pursuant to title 68, chapter 11, all senior centers, all community centers and all pharmacies shall post the following in the main public entrance:

(1) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office; and

(2) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect, and exploitation.

(b) The information listed in subsection (a) shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

(c) All nursing homes, assisted living facilities and any other residential facility licensed by the board of licensing health care facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number.

(d) Any licensed nursing home that complies with the requirements of § 68-11-254 shall be exempt from the requirements of subsections (a) and (b).

71-6-122. Telephone service to report abuse, neglect, and exploitation -- The division of adult protective services of the department of human services shall establish a toll-free telephone service to enable citizens within the state to call the division free of charge to report abuse, neglect, or exploitation and to see relevant assistance from the division in such matters.

APPENDIX 11-02

PAYMENT PROCEDURES

SECTION 11-02 PAYMENT PROCEDURES

11-02 PAYMENT PROCEDURES

11-02-01 Arranging for Examinations to be Paid by DHS and Procedures to Follow for Payment

The funds for examinations paid by the department are limited and must be used with discretion and only as a last option.

The following procedures should be followed to obtain the required examination(s) and to request payment:

Before Examination

- Locate a provider - physician, psychiatrist or psychologist (the psychologist must work in consultation with a physician) who agrees to do the required examination(s) at the established rate.

- Select a provider giving consideration to client preference, the quality of services provided, cost and location.

-Talk with the provider about the specific examination(s) being requested and determine the cost of the examination(s).

- Inform the provider the rate which will be paid based on the following schedule of maximum amounts:

Description/Units	Maximum Unit Cost
Medical, Psychological and Hospitalization	Not to exceed seventy percent (70%) of usual and customary charges.
Mental Health Center Services	Not to exceed eighty-five percent (85%) of usual and customary charges.
Psychological Services	Upper limit fee of $270.00 for routine type examination, $550.00 for neuropsychological examination.
Expenditures not to Exceed	$3,000.00

- Provide the provider with an Authorization to Vendor form.

- The completed Authorization to Vendor Form and the provider's invoice should be submitted to Fiscal Services, State Office for payment.

The Authorization to Vendor form, DPA# for **Examinations** is: **DP-99-01449-00.**

11-02-02 **Arranging for Interpreters Services and Procedures for Payment**

Interpreters Services: Authorization to Vendor form, **DPA#** is: **DP-99-01448-00**.

Five (5) qualified interpreters, based on the specific qualifications will be contacted and the services will be chosen based on availability and fees. The interpreter who has the lowest fee and is qualified and available will be selected.

The interpreter who provides the service shall submit his standard invoice for payment to the office of DHS which requested the services.

The requesting office of DHS shall certify that the services were received.

Fees paid shall be based upon the interpreter's qualifications as defined by the Registry of Interpreters for Deaf skill classifications.

The authorization to Vendor form must be completed and used for all payments and submitted with the invoice from the interpreter.

The maximum amount for any individual purchase is five hundred dollars and no cents, ($500.00).

The following is a schedule of the maximum amounts that can be authorized for these services:

Qualifications of the Interpreter	Maximum Cost
Level 1. Comprehensive Skills Certificate (CSC) or Oral Interpreter Certificate: Comprehensive (OIC:C) - Legal Assignments	$30.00 per hour
Level 2. Comprehensive Skills Certificate (CSC) or Oral Interpreter Certificate: Comprehensive (OIC:C) - Non-Legal Assignments	$27.00 per hour
Level 3. Transliterating Certificate (TC)	$24.00 per hour
Level 4. Non-Certified	$21.00 per hour

Any portion of a quarter hour will be paid as a quarter hour.

Travel expenses of the interpreter will be paid in accordance with State Travel Regulations.

The Tennessee Department of Human Services shall retain records to show the basis of each purchase.

11-02-03 **Authorization to Vendor Form**

The following form must be completed using the appropriate DPA#, based on whether an examination or interpreter services are being authorized.

The use of this form is infrequent; therefore, when a form is needed just copy the form for use.

APPENDIX 11-03

Memoranda of Understanding

Tennessee Department of Human Services

and

Tennessee Department of Health

MEMORANDUM OF UNDERSTANDING TENNESSEE DEPARTMENT OF HUMAN SERVICES AND TENNESSEE DEPARTMENT OF HEALTH FOR LICENSED FACILITIES

The Tennessee Department of Human Services, Adult Protective Services and the Department of Health, Division of Health Care Facilities, desire to enter into a memorandum of understanding in order to provide the best possible protection to residents of licensed health care facilities against abuse, neglect, or exploitation of adults.

The Tennessee Adult Protection Act (T.C.A. 71-6-101 et seq.) provides protection to residents of licensed health care facilities just as it mandates protective services for adults in other living arrangements. The law mandates that Adult Protective Services staff receive and investigate reports of abuse, neglect, or exploitation of adults. The investigation and provision of services to adults include basic requirements, such as:
notification of law enforcement and licensing authorities upon receipt of the referral, making a timely response, interviewing the adult client, determining the risks to the adult, providing appropriate intervention, maintaining confidential records, and notification of the referent after the investigation/assessment process has been completed.

The Department of Health, Division of Health Care Facilities scope of services includes the following:

- license health care facilities annually;
- conduct surveys for licensure, certification, and ensure that state minimum standards are met and federal conditions of participation are complied with;
- investigate complaints pertaining to health care facilities; and
- provide consultation to providers regarding the above.

Any time a Health Care Facilities employee observes, suspects, or is made aware of the possibility of abuse, neglect, exploitation of an adult, a report shall be made to the Department of Human Services, Adult Protective Services intake office by telephone. **Toll free number - 1-888-APS-TENN.**

In order to assist each department in investigating referrals or complaints concerning abuse, neglect or exploitation of specific adults, the following are expected responsibilities.

Department of Health, Health Care Facilities:

- Provide medical consultation to Adult Protective Services when requested to complete their investigation.

- Provide assistance to Adult Protective Services when requested to review the medical records.

- Assist in identifying an acceptable facility in which to admit the adult patient/resident.

- Assist in obtaining emergency approval when receiving facility's licensed bed capacity would be in excess if patient/resident was accepted.

- Ensures that all licensed health care providers take necessary action to protect the health and safety of. the patients/residents.

- Provides Adult Protective Services a detailed summary/investigative report of each complaint or referral investigated concerning abuse, neglect, or exploitation.

- Report immediately any abuse, neglect, or exploitation of an adult.

- Incorporate into a facility's deficiency report whenever the Department of Human Services, Adult Protective Services reports to Health Care Facilities that a facility did not report timely to Adult Protective Services in accordance with state law.
- Collaborate with Department of Human Services, Adult Protective Services throughout the investigative process.
- Encourages coordination of on-site visits and interviews when possible.
- If the referral is not accepted by APS, the Department of Health, Health Care Facilities will complete their investigation accordingly.

Department of Human Services, Adult Protective Services:

- Accept for investigation referrals which allege abuse, neglect or exploitation of specific adults in licensed facilities.
- Adult Protective Services will determine and advise Health Care Facilities staff if the referral is accepted for investigation and will identify the APS unit supervisor who will oversee the investigation.
- Notify law enforcement and the TBI-Medicaid Fraud Unit, when appropriate, of abuse, neglect, or exploitation allegations.
- Share with the Tennessee Department of Health/Division of Health Care Facilities all referrals (excluding the identity of the referent) of abuse, neglect or exploitation of adults in licensed facilities reported to TDHS/APS.
- Notify TDH/HCF immediately when APS receives any abuse or severe neglect referrals which allege physical or sexual abuse or life-threatening neglect. Referrals to APS received after hours will be reported on the next working day to the appropriate TDH regional office.
- Notify TDH within two (2) working days for all other APS referrals.
- Refer to TDH/HCF regional offices referrals alleging conditions which may be in violation of standards but are not of such a nature or degree as to warrant an APS investigation, (i.e. unsanitary/unsafe conditions, dirty linen, cold food or other general complaints which do not pose an immediate risk to the resident).

- Encourage when possible the coordination of investigations with TDH/HCF including scheduling of interviews, -etc. However, the APS investigation will be initiated within response timeframes required by APS policy.
- See and interview the APS client, making all reasonable efforts to communicate with and observe the client.
- Review any medical, personnel, or other records that are pertinent to the investigation.
- Contact any persons believed to have information which will assist in determining the client's condition, risk, and need for services.
- APS staff will request TDH/HCF assistance when needed to interpret records, charts, or to determine appropriateness of interventions used or suggested.

- TDHS/APS will share the results of the investigation with TDH/HCF. These reports shall remain confidential, shall be treated as a confidential part of TDH files, and under no circumstances will APS reports/files become part of a public record.

Differing investigative outcomes that negatively impact the intervention by either Adult Protective Services or Health Care Facilities will be reported to the Directors or the Assistant Commissioners of the Departments based on the request of the investigating staff.

The Tennessee Department of Human Services and the Tennessee Department of Health agree to respect the above-stated procedures and to share with appropriate staff of each department the understanding reached in this memorandum. It is the intent that each agency understand the legal responsibility/authority of the departments and to the greatest extent possible work cooperatively within the legal mandate of each agency.

Natasha K. Metcalf 9/20/00

Natasha K. Metcalf, Commissioner Date
Tennessee Department of Human Services

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Fredia S. Wadley, Commissioner **Date**
Tennessee Department of Health

MEMORANDUM OF UNDERSTANDING
TENNESSEE DEPARTMENT OF HUMAN SERVICES AND
TENNESSEE DEPARTMENT OF HEALTH FOR
UNLICENSED FACILITIES

The Tennessee Department of Human Services, Adult Protective Services and the Department of Health, Division of Health Care Facilities, desire to enter into a memorandum of understanding in order to provide the best possible protection to residents of unlicensed health care facilities against abuse, neglect, or exploitation of adults.

The Tennessee Adult Protection Act (T.C.A. 71-6-101 et seq.) provides protection to residents of unlicensed health care facilities just as it mandates protective services for adults in other living arrangements. The law mandates that Adult Protective Services staff receive and investigate reports of abuse, neglect, or exploitation of adults. The investigation and provision of services to adults include basic requirements, such as:
notification of law enforcement and licensing authorities upon receipt of the referral, making a timely response, interviewing the adult client; determining the risks to the adult, providing appropriate intervention, maintaining confidential records, and notification of the referent after the investigation/assessment process has been completed.

The Department of Health, Division of Health Care Facilities scope of services includes the following:

- license health care facilities annually;
- conduct surveys for licensure, certification, and ensure that state minimum standards are met and federal conditions of participation are complied with;
- investigate complaints pertaining to unlicensed health care facilities as the law permits;
- provide consultation to providers regarding the above; and
- communicate licensing requirements and facilitate application process.

Any time a Health Care Facilities employee observes, suspects, or is made aware of the possibility of abuse, neglect, or exploitation of an adult, a report shall be made to the Department of Human Services, Adult Protective Services intake office by telephone. **Toll free number - 1-888-APS-TENN.**

In order to assist each department in investigating referrals or complaints concerning abuse, neglect or exploitation of specific adults in unlicensed health care facilities, the following are expected responsibilities.

<u>Department of Health, Health Care Facilities:</u>

- Provide medical consultation to Adult Protective Services when requested to complete their investigation.

- Provide assistance to Adult Protective Services when requested to review the medical records.

- Assist in identifying an acceptable facility in which to admit the adult patient/resident.

- Assist in obtaining emergency approval when receiving facility's licensed bed capacity would be in excess if patient/resident was accepted.

- Will take necessary actions as the law permits to protect the health and safety of the patients/residents in unlicensed health care facilities, i.e. reporting to any professional board, district attorney, TBI, and APS.

- Provides Adult Protective Services a detailed summary/investigative report of each complaint or referral if investigated.

- Report immediately any abuse, neglect, or exploitation of an adult.

- Collaborate with Department of Human Services, Adult Protective Services throughout the investigative process.

- Encourages coordination of on-site visits and interviews when possible.

- If the referral is not accepted by APS, the Department of Health, Health Care Facilities will adhere to their investigation/reporting procedures to TBI, and district attorneys accordingly.

Department of Human Services, Adult Protective Services:

- Accept for investigation referrals which allege abuse, neglect or exploitation of specific adults in unlicensed health care facilities.

- Adult Protective Services will determine and advise Health Care Facilities staff if the referral is accepted for investigation and will identify the APS unit supervisor who will oversee the investigation.

- Notify law enforcement and the TBI-Medicaid Fraud Unit, when appropriate, of abuse, neglect, or exploitation allegations.

- Share with the Tennessee Department of Health/Division of Health Care Facilities all referrals (excluding the identity of the referent) of abuse, neglect, including self-neglect, or exploitation of adults identified as living in unlicensed health care facilities which are reported to TDHS/APS.

- Notify TDH/HCF immediately when APS receives any abuse or severe neglect referrals which allege physical or sexual abuse or life-threatening neglect of residents identified as living in unlicensed health care facilities. Referrals to APS received after hours will be reported on the next working day to the appropriate TDH regional office.

- Notify TDH within two (2) working days for all other APS referrals that relate to residents identified as living in an unlicensed health care facility.

- Refer the caller to TDH/HCF regional offices for referrals alleging conditions in an unlicensed health care facility which may be in violation of standards but are not of such a nature or degree as to warrant an APS investigation, (i.e. unsanitary/unsafe conditions, dirty linen, cold food or other general complaints which do not pose an immediate risk to the resident)

- See and interview the APS client, making all reasonable efforts to communicate with and observe the client.
- Review any medical, personnel, or other records that are pertinent to the investigation.

- Contact any persons believed to have information which will assist in determining the client's condition, risk, and need for services.

- APS staff will request TDH/HCF assistance when needed to interpret records, charts, or to determine appropriateness of interventions used or suggested.

- TDHS/APS will share the results of the investigation with TDH/HCF. These reports shall remain confidential, shall be treated as a confidential part of TDH files, and under no circumstances will APS reports/files become part of a public record.

Differing investigative outcomes that negatively impact the intervention by either Adult Protective Services or Health Care Facilities will be reported to the Directors or the Assistant Commissioners of the Departments based on the request of the investigating staff.

The Tennessee Department of Human Services and the Tennessee Department of Health agree to respect the above-stated procedures and to share with appropriate staff of each department the understanding reached in this memorandum. It is the intent that each agency understand the legal responsibility/authority of the departments and to the greatest extent possible work cooperatively within the legal mandate of each agency.

Natasha K. Metcalf, Commissioner
Tennessee Department of Human Services

9/20/00
Date

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Fredia S. Wadley, Commissioner
Tennessee Department of Health

9/22/00
Date

APPENDIX 11-04

TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES AND THE PATIENT CARE ADVOCATE PROGRAM

The Health Care Facilities Division has responsibility for regulating Nursing Homes and Residential Homes for the aged. The appropriate office should be advised when there are adults in Nursing Homes or Residential Homes for the Aged reported to be abused, neglected, or exploited; or there are concerns about the quality of care in a facility.

The Patient Care Advocate Program has responsibility for serving as an advocate for adults in Nursing Homes and Residential Homes for the Aged. The Patient Care Advocate is located in the Tennessee Department of Health, State Office.

Katy Gammon, Director
Division Health Care Facilities

Cordell Hull Bldg. -1st Floor
426 5th Avenue North
Nashville, TN 37247-0508
(615) 741-7221 Fax: (615) 741-7051

- **Complaint Investigation**
- **Facility Inspection & Surveys**
- **Professional Consultation & Technical Assistance**

Shirley Jones
West TN
Regional Administrator

781-B Airways Blvd.
Jackson, TN 38301

(731) 423-6454

FAX: (731) 423-6572

Nina Monroe
Middle TN
Regional Administrator

710 Hart Lane, 1st Floor
Nashville, TN 37217

(615) 650-7100

FAX: (615) 650-7101

Faye Vance
East TN
Regional Administrator
Health Care Facilities

5904 Lyons View Pike, Bldg. 1
Knoxville, TN 37919

(865) 588-5656

FAX: (865) 594-5739

Lynn O'Neal, Director
Patient Care Advocate Program

Cordell Hull Bldg. 3rd Floor
425 5th Avenue North
Nashville, TN 37247
(615) 741-5879 Fax: (615) 741-0544

- **Patient Trust Issues**
- **PAE Denials**
- **Inappropriate Place Patients**
- **Patient Right Violations**
- **Involuntary Transfers**
- **Abuse and Neglect**

APPENDIX 11-05

TENNESSEE DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS

The Tennessee Department of Health is responsible for licensure of professional staff who are licensed under state law in Tennessee. The licensing board of each profession has the authority to discipline licensed members of the profession. This action may include but is not limited to requiring additional training, suspending or revoking the license, etc.

Robbie H. Bell, Director
Division of Health Related Boards
Cordell Hull Building, 1st Floor
425 5th Avenue North
Nashville, TN 37247-1010
(615) 532-9418
FAX: (615) 253-1535

1215 Sent To:

Denise Moran, Director
Investigations Division
Health Related Boards
Cordell Hull Building, 3rd Floor
425 5th Avenue North
Nashville, TN 37247
(615) 532-3425 (Direct)
Office: 741-8485
FAX (615) 532-2499

- Optometry Board
- Hearing Aid Dispensers Board
- Professional Counselors & Marital & Family Therapists
- Medical Examiners Board
- Osteopathy Physician Board -
- Chiropractors Board
- Dispensing Opticians Board
- Physical Therapy/Occupational Therapy Board
- Nursing Home Administrators Board
- Dentistry Board
- Environmentalist Board
- Psychology Board
- Podiatry Board
- Speech Pathology Board
- Audiology Board
- Nursing Board
- Board of Social Workers

APPENDIX 11-06

TENNESSEE DEPARTMENT OF
MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
LICENSURE DIVISION

The Tennessee Department of Mental Health/Developmental Disabilities has responsibility for licensure of residential facilities which serve mentally ill or developmentally disabled persons. The appropriate Licensure Coordinator should be notified when there are concerns about the quality of care provided in residential facilities licensed by TDMH/DD.

Arthur Hyde
Director of Licensure
Office of the Director
Licensure Division

Cordell Hull Building, 5th Fl.
425 5th Ave. No.
Nashville, TN 37243-
(615) 532-6590
Fax: (615) 532-7856

Cynthia Headrick
East Tenn. Licensure Coordinator
East Tenn. Licensure Office
State Office Building
531 Henley Street, Suite 503
Knoxville, TN 37902-2898
(865) 594-6551

Ann Turner Brooks
Middle Tenn. Licensure Coordinator
Middle Tenn. Licensure Office
Cordell Hull Building, 5th Fl.
425 5th Ave. No
Nashville, TN 37243-
(615) 532-6594

Phil Brown
West Tenn. Licensure Coordinator
West Tenn. Licensure Office
12th Floor
170 North Main St.
Memphis, TN 38103-0509
(901) 543-7442

APPENDIX 11-07

DOMESTIC ABUSE ACT

T.C.A., TITLE 36

DOMESTIC ABUSE ACT
T.C.A., TITLE 36

36-3-601. Definitions. - For the purpose of this part, unless the context clearly Indicates otherwise:

(1) **"Abuse"** means inflicting or attempting to inflict physical injury on an adult by other than accidental means, physical restraint, or malicious damage to the personal property of the abused party;

(2) **"Adult"** means any person eighteen (18) years of age or older, or who is otherwise emancipated;

(3)(A) **"Court,"** in counties having a population of not less than two hundred thousand (200,000) nor more than eight hundred thousand (800,000) according to the 1980 federal census or any subsequent federal census, means any court of record with jurisdiction over domestic relation matters;

(B) Notwithstanding the provisions of subdivision (A), "Court," in counties with a metropolitan form of government with a population of more than one hundred thousand (100,000) according to the 1990 federal census or any subsequent federal census, means any court of record with jurisdiction over domestic relation matters and the general sessions court. In such county having a metropolitan form of government, a judicial commissioner may issue an ex parte order of protection. Nothing in this definition may be construed to grant jurisdiction to the general sessions court for matters relating to child custody, visitation, or support;

(C) "Court," in all other counties, means any court of record with jurisdiction over domestic relation matters or the general sessions court of the county in which the petition resides;

(4) **"Family or household member"** means:

(A) Spouses;

(B) Persons living as spouses;

(C) Persons related by blood or marriage;

(D) A respondent who is the parent of the petitioner's child;

(E) Persons whose sexual relationship has resulted in a current pregnancy; and

(F) Other persons jointly residing in the same dwelling unit, who are eighteen (18) years of age or older, or who are emancipated;

(5) **"Petitioner"** means person alleging abuse in petition for order for protection; and

(6) **"Respondent"** means person alleged to have abused another in a petition for orders for protection;

(7) **"Firearm"** means any weapon designed, made or adapted to expel a projectile by the action of an explosive or any device readily convertible to that use;

(8) **"Preferred response"** means law enforcement officers shall arrest a person committing domestic abuse unless there is a clear and compelling reason not to arrest;

(9) **"Victim"** means a family or household member who is the subject of domestic abuse and who a law enforcement officer has determined is not a primary aggressor under the factors set out in § 36-3-619(c); and

(10) **"Weapon"** means a firearm or a device listed in § 39-17-1302(a)(1)-(7), [Acts 1979, ch. 350, § 1; T.C.A., § 36-1201; Acts 1988, ch. 925, §§ 1, 2; 1991, ch. 380, § 1; 1994, ch. 764, § 1; 1995, ch 507, § 3.]

36-3-604. Forms. - (a) The office of the clerk of court shall provide forms which may be necessary to seek a protection order under this part. These forms shall be limited to use in causes filed under this part and they shall be made available to all who request assistance in filing a petition. The petitioner is not limited to the use of these forms and may present to the court any legally sufficient petition in whatever form. The office of the clerk shall also assist a person who is not represented by counsel by filling in the name of the court on the petition, by indicating where the petitioner's name shall be filled in, by reading through the petition form with the petitioner, and by rendering any other such assistance as is necessary for the filing of the petition. All such petitions which are filed pro se shall be liberally construed in favor of the petitioner.

(b) The office of the clerk shall make available the following blank forms and/or such other forms as may be ordered by the court:

(1)

IN THE _____COURT OF _____ COUNTY, TENNESSEE

_____,)
PETITIONER,)
VS.) NO. _____
_____,)
RESPONDENT.

PETITION FOR ORDERS OF PROTECTION

Petitioner, _____, pursuant to Tennessee Code Annotated, chapter 3, part 6 of this title, states:

1. Petitioner is a resident of _____ County, Tennessee. Respondent is a resident of _____ County, Tennessee, and lives at _____. The incident which gives rise to this petition occurred in _____ County, Tennessee.

2. Petitioner and respondent are present or former family or household members.

3. The parties have _____ minor child(ren); (Write name and age of each child on the following blank lines.)

_____
_____
_____
_____

4. Respondent has abused and/or threatened to abuse petitioner. Specifically, respondent has: (Write what happened, when it happened, and where it happened on the following lines.)

_____
_____
_____
_____
_____
_____

5. Petitioner is in an immediate and present danger of abuse by respondent. (For paragraphs 6 through 8, check only if the particular paragraph is applicable.)

____6. Petitioner needs support for the parties' minor child(ren).

____7. Petitioner needs support for the petitioner.

____8. Respondent refuses to leave from the parties' residence. (If you check paragraph 8, please check one (1) of the following.)

____ A. Respondent is the sole _____ of the parties residence.

(owner or lessee)

____ B. Respondent is not the sole owner or lessee of the parties' residence.

WHEREFORE, PETITIONER PRAYS:

1. That an *ex parte* Order of Protection, as provided for in Tennessee Code Annotated,
§ 36-3-605, be immediately issued enjoining respondent from abusing or threatening abuse of the petitioner and that copies of the order be served upon the respondent and filed with the _____ County Sheriff;

2. That a hearing in this cause be set for within ten (10) days pursuant to Tennessee Code Annotated, § 36-3-605, and that notice of the hearing be served upon respondent together with the Order of Protection;

3. That upon the hearing of this cause, petitioner be granted an extended Order of Protection for a period of one hundred twenty (120) days;

_____

(For paragraphs 4 through 7, check only if the particular paragraph is applicable.)

___4. That upon the hearing of this cause, petitioner be awarded temporary custody of the parties' minor child(ren);

___5. That upon the hearing of this cause, respondent be ordered to pay reasonable support for petitioner;

___6. That upon the hearing of this cause, respondent be ordered to pay reasonable support for the parties' child(ren);

___7. That upon the hearing of this cause, exclusive possession of the parties' residence be awarded to petitioner, or that respondent be ordered to provide alternate housing for petitioner;

8. That respondent pay the costs and litigation tax of this cause;

9. For general relief.

_____
PETITIONER

THIS IS THE FIRST APPLICATION FOR EXTRAORDINARY PROCESS IN THIS CAUSE.

STATE OF TENNESSEE)
COUNTY OF _____)

_____, being first duly sworn, makes oath that the petitioner has read the foregoing petition, knows the contents thereof, and that the same is true and correct to the best of the petitioner's knowledge, information and belief.

_____
PETITIONER

Sworn to and subscribed before me this _____ day of _____, 19___

_____
NOTARY PUBLIC OR CLERK

My Commission expires: _____

(2)
IN THE _____ COURT OF _____ COUNTY, TENNESSEE

_____ ,	)	
PETITIONER,	)	
VS.	)	NO. _____
_____ ,	)	
RESPONDENT.	)	

Any resident of the state who wishes to file a petition asking for a protection order but who cannot afford to pay the cost of litigation tax may file a petition after swearing under oath that he or she cannot pay.

MOTION TO PROCEED IN FORMA PAUPERIS

Petitioner moves the Court for leave to proceed in *forma pauperis* on the ground that the petitioner is unable to prepay filing fees and litigation tax. In support of this motion, petitioner relies upon the following oath:

I, _____, do solemnly swear that owing to my poverty I am not able to bear the expense of the action in which I am about to commence, that I am justly entitled to the relief sought to the best of my belief.

_____
PETITIONER

ORDER

It is hereby ordered that petitioner is _____ leave to proceed in forma pauperis.

Entered this the _____ day of _____, 19___.

_____
JUDGE

(3)

IN THE _____ COURT OF _____ COUNTY, TENNESSEE

_____ ,)
PETITIONER,)
VS.) NO. _____
_____,)
RESPONDENT.)

EX PARTE ORDER OF PROTECTION

TO THE RESPONDENT, _____:

It appears to the Court from the sworn petition for an order of protection, that such an order should issue pursuant to Tennessee Code Annotated, title 36, chapter 3, part 6.

IT IS, THEREFORE, ORDERED, ADJUDGED, AND DECREED:

1. That respondent, _____, is restrained and prohibited from abusing, threatening to abuse, or committing acts of violence upon petitioner;
2. That if respondent violates this order, the respondent may be held in contempt of Court and punished by incarceration in the _____ County Jail.
3. That a hearing on this matter will be held on the ____ day of _____, 19 ___, at _____, in the _____ Court of _____ County, Tennessee; and that respondent has a right to secure counsel to represent him or her at the hearing.
4. That, pursuant to Tennessee Code Annotated, § 36-3-609, a copy of this Order be issued to all local law enforcement agencies in _____ County.
5. That, pursuant to Tennessee Code Annotated, § 36-3-611, respondent may be arrested by a law enforcement officer without a warrant if that officer has reasonable cause to believe that respondent has violated or is violating this Order;

ENTERED this _____ day of _____, 19 _____.

_____
JUDGE

OFFICER'S RETURN

Served on respondent by personally reading the Notice to respondent and by leaving a copy of the Notice with respondent on the ____ day of _____, 19____, ____.m.

_____
SHERIFF - DEPUTY SHERIFF

(4)
IN THE _____ COURT OF _____ COUNTY, TENNESSEE

_____,)
PETITIONER,)
VS.) NO. _____
_____,)
RESPONDENT.)

NOTICE

TO THE RESPONDENT, _____:

Notice is hereby given to you, _____, that the petitioner shall appear before the Honorable _____ _____, _____ of the _____ Court for _____ County, Tennessee, on the _____ day of _____, 19 _____, requesting the Court to extend the ex parte Order of Protection previously entered in this cause, and to award the relief prayed for in the Petition for Orders of Protection.

The hearing is to be held at _____.m. and you may be represented by counsel if you so choose.

IF YOU WANT TO TELL YOUR SIDE TO THE JUDGE, YOU MUST BE AT THE HEARING ON _____, 19 _____. IF YOU DO NOT COME TO THE HEARING, THE JUDGE WILL DECIDE BASED ONLY ON YOUR SPOUSE'S TESTIMONY.

_____
CLERK

Served on respondent by personally reading the Notice to him and be leaving a copy of the Notice with him on the _____ day of _____, 19 _____, _____.m.

_____
DEPUTY SHERIFF

(5)
IN THE _____ COURT OF _____
COUNTY, TENNESSEE

_____,)
PETITIONER,)
VS.) NO. _____
_____,)
RESPONDENT

ORDER OF PROTECTION

This cause came on to be heard upon petitioner's petition for orders of protection on the _____ day of _____,
19 _____, upon notice duly served on the respondent and upon statements made in open Court. From the entire record herein, the Court finds that the petitioner has proved the allegations of abuse by a preponderance of the evidence.

IT IS, THEREFORE, ORDERED that the respondent is enjoined from coming about petitioner for any purpose and specifically from abusing, threatening to abuse petitioner, or committing any acts of violence upon petitioner upon penalty of contempt.

IT IS FURTHER ORDERED AS FOLLOWS:

1. That, if respondent violates this order, the respondent may be held in contempt of Court and punished by incarceration in the _____ County Jail.
2. That, pursuant to Tennessee Code Annotated, § 36-3-609, a copy of this Order be issued to all local law enforcement agencies in _____ County.
3. That, pursuant to Tennessee Code Annotated, § 36-3-611, respondent may be arrested by a law enforcement officer without a warrant if that officer has reasonable cause to believe that respondent has violated or is violating this Order.

IT IS ORDERED AS FOLLOWS:
(X where applicable)

_____ The petitioner is awarded custody of the parties' minor child(ren),
_____
_____

_____ Respondent shall pay $ _____ per _____ for the support of the parties' minor child(ren), the payments to be made to the Clerk's office, together with the Clerk's fee of five percent (5%) ($), for the total payment each _____ of $_____;

_____Respondent shall pay $ _____ per _____ for the support of petitioner; the payments to be made to the Clerk's office, together with the Clerk's fee of five percent (5%) ($), for a total payment each _____ of $_____;

_____Petitioner is awarded exclusive possession of the parties' residence located at _____, and respondent is evicted therefrom;

_____Respondent shall provide suitable alternative housing for petitioner by the _____ day of _____, 19 ___.

IT IS FURTHER ORDERED, that respondent shall pay the costs and litigation tax of this cause.

IT IS FURTHER ORDERED, that this Order shall remain in effect for a period on one hundred twenty (120) days, and petitioner, upon notice to respondent, may request a continuation of the Order.

ENTERED this _____ day of _____, 19 _____.

_____
JUDGE

CERTIFICATE

Served on the respondent by personally reading the Order to him and by leaving a copy of the Order with him on the _____ day of _____, 19 ____, _____.m.

(c) In counties having a population of more than seven hundred thousand (700,000), according to the 1990 federal census or any subsequent federal census, the fees authorized for the clerk in subsection (b) shall be ten percent (10%).
[Acts 1979, ch. 350, § 4; 1982, ch. 935, § 1; T.C.A., § 36-1204; Acts 1987, ch. 270, § § 2-5; 1995, ch. 410, § 2; 1995, ch. 456, § 6.]

36-3-606. Scope of protection order. - (a) A protection order granted under this part to protect the petitioner from domestic abuse may include, but is not limited to:

(1) Directing the respondent to refrain from committing domestic abuse or threatening to commit domestic abuse against the petitioner;

(2) Prohibiting the respondent from telephoning, contacting, or otherwise communicating with the petitioner, directly or indirectly;

(3) Prohibiting the respondent from stalking the petitioner, as defined in § 39-17-315;

(4) Granting to the petitioner possession of the residence or household to the exclusion of the respondent by evicting the respondent, by restoring possession to the petitioner or by both;

(5) Directing the respondent to provide suitable alternate housing for the petitioner when the respondent is the sole owner or lessee of the residence or household;

(6) Awarding temporary custody of, or establishing temporary visitation rights with regard to any minor children born to or adopted by the parties; or

(7) Awarding financial support to the petitioner and such persons as the respondent has a duty to support. Except in cases of paternity the Court shall not have the authority to order financial support unless the petitioner and respondent are legally married. Such order may be enforced pursuant to Chapter 5 of this title.

(b) Relief granted pursuant to subdivisions (a) (4)-(7) of this section shall be ordered only after the petitioner and respondent have been given an opportunity to be heard by the court.

(c) Any order of protection issued under this part shall include the statement of the maximum penalty which may be imposed pursuant to § 36-3-610 for violating such order.

(d) No order of protection made under this part shall in any manner affect title to any real property.

(e) If the petitioner is a family or household member as defined in § 36-3-601(4)(D) or (E), the provisions of subdivisions (a)(4) and(5) shall not apply to such petitioner. [Acts 1979, ch. 350, §§ 6-8; T.C.A., §§ 36-1206 - 36-1208.; Acts 1987, ch. 270, §§ 7, 12; 1991, ch. 380, § 4; 1995, ch. 507, § 4.]

36-3-609. Copies of protection order to be issued. - A copy of any order of protection and any subsequent modifications shall be issued to the petitioner, the respondent, and the local law-enforcement agencies having jurisdiction in the area where the petitioner resides. The officer serving the order of protection shall read the order to the respondent. Upon receipt of the copy of the order of protection, the local law enforcement agency shall enter such order in the Tennessee crime information system. [Acts 1979, ch. 350, § 11; T.C.A.; § 36-1211.; Acts 1987, ch. 270, § 8; 1993, ch. 484, § 2.]

36-3-610. Violation of order or consent agreement - Civil or criminal contempt. - Financial penalty. - (a) Upon violation of the order of protection or a court-approved consent agreement, the court may hold the defendant in civil or criminal contempt and punish him in accordance with the law. A judge of the general sessions court shall have the same power as a court of record to punish the defendant for contempt when exercising jurisdiction pursuant to this part or when exercising concurrent jurisdiction with a court of record. A judge of the general sessions court who is not a licensed attorney shall appoint an attorney referee to hear charges of criminal contempt.

(b) In addition to the authorized punishment for contempt of court, the judge may assess any person who violates an order of protection or a court-approved consent agreement a civil penalty of fifty dollars ($50.00). The judge may further order that any support payment made pursuant to an order of protection or a court approved consent agreement he made under an income assignment to the clerk of the court.

(c) ....

36-3-615. Notification to victim that family or household member arrested for assault may be released on bond. - (a) After a family or household member has been arrested for assault pursuant to § 39-13-101 against another family or household member or aggravated assault pursuant to § 39-13-102 against another family or household member, the arresting officer shall inform the victim that the person arrested may be eligible to post bond for the offense and be released until the date of trial or the offense.

(b) subsection (a) is solely intended to be a notification provision, and no cause of action is intended to be created thereby. [Acts 1993, ch. 436 §§ 1,2.]

36-3-616....

36-3-617. Protection order - Filing costs and assistance. - Notwithstanding any other provision of law to the contrary, the petitioner shall not be required to pay any filing fees, litigation taxes or any other costs associated with the filing issuance or enforcement of an order of protection authorized by this part upon the filing of the petition. The judge shall assess court costs and litigation taxes at the hearing of the petition or upon dismissal of the petition. The clerk of the court may provide order of protection petition forms to agencies that provide domestic violence assistance. Any agency that meets with a victim in person and recommends that an order of protection be sought shall assist the victim in the completion of the form petition for filing with the clerk. No agency shall be required to provide this assistance unless it has been provided with the appropriate forms by the clerk. [Acts 1995, ch. 410, § 3.]

36-3-618. Purpose - Legislative intent. - The purpose of this part is to recognize the seriousness of domestic abuse as a crime and to assure that the law provides a victim of domestic abuse with enhanced protection from domestic abuse. A further purpose of this chapter is to recognize that in the past law enforcement agencies have treated domestic abuse crimes differently than crimes resulting in the same harm but occurring between strangers. Thus, the general assembly intends that the official response to domestic abuse shall stress enforcing the laws to protect the victim and prevent further harm to the victim, and the official response shall communicate the attitude that violent behavior is not excused or tolerated. [Acts 1995, ch. 507, § 2.]

36-3-619. Officer response - Primary aggressor - Factors - Reports - Notice to victim of legal rights. - (a) If a law enforcement officer has probable cause to believe that a person has committed a crime involving domestic abuse, whether the crime is a misdemeanor or felony, or was committed within or without the presence of the officer, the preferred response of the officer is arrest.

(b) If a law enforcement officer has probable cause to believe that two (2) or more persons committed a misdemeanor or felony, or if two (2) or more persons make complaints to the officer, the officer shall try to determine who was the primary aggressor. Arrest is the preferred response only with respect to the primary aggressor. The officer shall presume that arrest is not the appropriate response for the person or persons who were not the primary aggressor. If the officer believes that all parties are equally responsible, arrest is not the preferred response for any party, and the officer shall exercise that officer's best judgment in determining whether to arrest any parties.

(c) To determine who is the primary aggressor, the officer shall consider:

(1) The history of domestic abuse between the parties;

(2) The relative severity of the injuries inflicted on each person;

(3) Evidence from the persons involved in the domestic abuse;

(4) The likelihood of future injury to each person;

(5) Whether one (1) of the persons acted in self-defense; and

(6) Evidence from witnesses of the domestic abuse.

(d) A law enforcement officer shall not:

(1) Threaten, suggest, or otherwise indicate the possible arrest of all parties to discourage future requests for intervention by law enforcement personnel; or

(2) Base the decision of whether to arrest on:

(A) The consent of request of the victim; or

(B) The officer's perception of the willingness of the victim or of a witness to the domestic abuse to testify or participate in a judicial proceeding.

(e) When a law enforcement officer investigates an allegation that domestic abuse occurred, the officer shall make a complete report and file the report with the officer's supervisor in a manner that will permit data on domestic abuse cases to be compiled. If a law enforcement officer decides not to make an arrest or decides to arrest two (2) or more parties, the officer shall include in the report the grounds for not arresting anyone or for arresting two (2) or more parties.

(f) Every month, the officer's supervisor shall forward the compiled data on domestic abuse cases to the administrative director of the courts.

(g) When a law enforcement officer responds to a domestic abuse call, the officer shall;

(1) Office to transport the victim to a place of safety, such as a shelter or similar location or the residence of a friend or relative, unless it is impracticable for the officer to transport the victim, in which case the officer shall offer to arrange for transportation as soon as practicable;

(2) Advise the victim of a shelter or other service in the community; and

(3) Give the victim notice of the legal rights available by giving the victim a copy of the following statement:

IF YOU ARE THE VICTIM OF DOMESTIC ABUSE, you have the following rights:

1. You may file a criminal complaint with the District Attorney General (D.A.).
2. You may request a protection order. A protection order may include the following:

(A) an order preventing the abuser from committing further domestic abuse against you,

(B) an order requiring the abuser to leave your household,

(C) an order preventing the abuser from harassing you or contacting you for any reason,

(D) an order giving you or the other parent custody of or visitation with your minor child or children,

(E) an order requiring the abuser to pay money to support you and the minor children if the abuser has a legal obligation to do so, and

(F) an order preventing the abuser from stalking you.

The area crisis line is _____

The following domestic abuse shelter/programs are available to you:

_____

_____

[Acts 1995, ch. 507, § 5.]

36-3-620. Seizure of weapons in possession of alleged abuser. - (a)(1) If a law enforcement officer has probable cause to believe that a criminal offense involving abuse against a family or household member, as defined in § 36-3-601, has occurred, the officer shall seize all weapons that are alleged to have been used by the abuser or threatened to be used by the abuser in the commission of a crime.

(2) Incident to an arrest for a crime involving abuse against a family or household member, as defined in § 36-3-601, a law enforcement officer may seize a weapon that is in plain view of the officer or discovered pursuant to a consensual search, if necessary for the protection of the officer or other persons; provided, that a law enforcement officer is not required to remove a weapon such officer believes is needed by the victim for self-defense.

(b) The provisions of § 39-17-1317, relative to the disposition of confiscated weapons shall govern all weapons seized pursuant to this section that were used or threatened to be used by the abuser to commit the crime; provided, that if multiple weapons are seized, the court shall have the authority to confiscate only the weapon or weapons actually used or threatened to be used by the abuser to commit the crime. All other weapons seized shall be returned upon disposition of the case. Also, the officer shall append an inventory of all seized weapons to the domestic abuse report that the officer files with the officer's supervisor pursuant to § 36-3-619(e).

APPENDIX 11-08
LONG -TERM CARE OMBUDSMAN PROGRAM
Adrian D. Wheeler
STATE LONG-TERM CARE OMBUDSMAN, TN COMMISSION ON AGING, 500 DEADERICK ST. - 9TH FLOOR, NASHVILLE, TN 37243-0860
(615) 741-2056 FAX: (615) 741-3309

FIRST TN DISTRICT
Vickie Snodgrass
Legal Aid of East TN
311 West Walnut St. (37604-6786)
PO Drawer 360
Johnson City, TN 37605-0360
(423) 928-8311 ext. 27
Fax: (423) 928-9488

COUNTIES
Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington

EAST TN DISTRICT
Howard N. Hinds
E. TN Human Resource Agency
9111 Cross Park Dr., Suite D-100
Knoxville, TN 37923-4517
(865) 691-2551 ext. 212
Fax: (865) 531-7216

COUNTIES
Anderson, Blount, Campbell, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, Union

SOUTHEAST TN DISTRICT
Trudy Mott
Partnership for Families, Children and Adults
225 East Eighth St.
PO Box 11398
Chattanooga, TN 37401-2398
(423) 755-2877
Fax: (423) 755-2755

COUNTIES
Bledsoe, Bradley, Grundy, Hamilton, McMinn, Marion, Meigs, Polk, Rhea, Sequatchie

UPPER CUMBERLAND DISTRICT
Marie Ferran
Aging Svcs. for the Upper Cumberland, Inc.
1225 South Willow Ave.
Cookeville, TN 38506-4194
(931) 432-4210
Fax: (931) 432-6010

COUNTIES
Cannon, Clay, Cumberland, Dekalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, Van Buren, Warren, White

GREATER NASHVILLE DISTRICT
Donna Ray Anthony
Patricia Brinkley
Mid-Cumberland Human Resource Agency
The Oaks Tower
1101 Kermit Drive, Suite 300 (37217-5109)
PO Box 17385
Nashville, TN 37217-0385
(615) 850-3922
Fax: (615) 833-2585

COUNTIES
Chetham, Davidson, Dickson, Houston, Humphreys, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, Wilson

SOUTHCENTRAL TN DISTRICT
Cheryl Lynne Vallance
South Central TN Human Resource Agency
606 Lee Ave. (37334-2428)
PO Box 638
Fayetteville, TN 37334-0638
(931) 433-7182 ext. 103
Fax: (931) 424-3210
Second Office Hours 9:00 - 1:00
Pulaski (931) 424-5386 Fax: (931) 424-5386

COUNTIES
Bedford, Coffee, Franklin, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, Wayne

NORTHWEST TN DISTRICT
Marchell Gardner
Northwest Dev. District
124 Weldon Drive (38237-1308)
PO Box 963
Martin, TN 38237-0963
(731) 587-4213
Fax: (731) 588-5833

COUNTIES
Benton, Carroll, Crockett, Dyer, Gibson, Henry, Lake, Obion, Weakley

SOUTHWEST TN DISTRICT
Amanda Scott
Senior Citizens Law Project
PO Box 2966
210 West Main St.
Jackson, TN 38302-2066
(731) 426-1312
Fax: (731) 423-1362

COUNTIES
Chester, Decatur, Hardeman, Hardin, Haywood, Henderson, McNairy, Madison

MEMPHIS DELTA DISTRICT
Sandra Smegelsky
Metropolitan Inter-Faith Association
910 Vance Ave. (38216-2911)
PO Box 3130
Memphis, TN 38173-0130
(901) 527-0208 ext. 215
Fax: (901) 523-1266

COUNTIES
Fayette, Lauderdale, Shelby, Tipton

APPENDIX 11-09

EMERGENCY TELEPHONE APPROVAL OF PRE-ADMISSION EVALUATIONS

An emergency system for PAE approvals went into effect July, 1985 to expedite approvals of PAE's in some emergency Adult Protective Services cases. The following is a list of the contacts at the TDH designated to handle emergency approvals. See **Section 5-13-04 f**or policy on emergency approvals of PAEs.

Pat Santel
Director, Long Term Care
729 Church St.
Nashville, TN 37247-6501
(615)-741-0212

Koral Cooper
Nurse Manager
(615) 741-0212

APPENDIX 11-10

PUBLIC CONSERVATOR LIST

PUBLIC GUARDIANSHIP FOR THE ELDERLY PROGRAM

Jeanne E. Caudill, L.C.S.W, Coordinator for the
Public Guardianship for the Elderly Program
Tennessee Commission on Aging & Disability
500 Deaderick St., Suite 825
Nashville, TN 37243-0860
Phone: (615) 741-2056
Fax: (615) 741-3309

Wanda Martin, District Public Conservator
Marie Bennett, Assistant (423)722-5105)
First TN District Area Agency on Aging
207 N. Boone St.
Johnson City, TN 37604-5699
(**423) 722-5104**
Fax: (423) 928-5209

Counties: Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington

Christy Warren,
District Public Conservator
Pauline Moore Assistant (931- 490-5883)
South Central Area Agency on Aging
810 So Main Street, PO Box 1346
Columbia, TN 38402-1346
(**931) 490-5888**
Fax: (931) 381-2056

Counties: Bedford, Coffee, Franklin, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, Wayne

Carol V. Silvey,
District Public Conservator
Denise Manz, Assistant (865-691-2551)
East TN Area Agency on Aging
9111 Cross Park Drive, Suite D-100
Knoxville, TN 37923
(865) 691-2551 ext. 218
Fax: (865) 531-7216

Counties: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, Union

Jeanine Smith,
District Public Conservator
Sherol Sebring, Assistant Public Conserv.
Northwest TN Area Agency on Aging
124 Weldon Dr., P.O. Box 963
Martin, TN 38237-0963
(731) 587-4213
Fax: (731) 588-0441

Counties: Benton, Carroll, Crockett, Dyer, Gibson, Henry, Lake, Obion, Weakley

PUBLIC GUARDIANSHIP FOR THE ELDERLY PROGRAM CON'T

Darlene H. Burnette,
District Public Conservator
Brandy Garrett, Assistant (423- 424-4273)
Southeast TN Area Agency on Aging
535 Chestnut St., Suite 300 (37402-4949)
PO Box 4757
Chattanooga, TN 37405-0757
(423) 424-4274
Fax: (423) 424-4225

Counties: Bledsoe, Bradley, Grundy, Hamilton, McMinn, Marion, Meigs, Polk, Rhea, Sequatchie

Ann F. Mayo, District Public Conservator
Marilyn Newbern, Assist. (731-688-6419)
Southwest TN Area Agency on Aging
27 Conrad Drive, Suite 150
Jackson, TN 38305-2850
(731) 668-6405
Fax: (731) 668-6421

Counties Chester, Decatur, Hardeman, Hardin, Haywood, Henderson, McNairy, Madison

Kelly Tayes, District Public Conservator
Sue Jolly, Assistant Conservator
Upper Cumberland Area Agency on Aging
1225 South Willow Avenue
Cookeville, TN 38506-4194
(931) 432-4111
FAX: (931) 432-6010

Counties: Cannon, Clay, Cumberland DeKalb, Fentress, Jackson, Macon Overton, Pickett, Putnam, Smith Van Buren, Warren, White

Peggy F. Dobbins,
District Public Conservator
Kimberly Clark, Acting Assistant
(901-324-6333)
The Aging Commission of the Mid-South
2670 Union Avenue Extended, Suite 1000
Memphis, TN 381112-4416
(901) 324-6333
FAX: (901) 327-7755

Counties: Fayette, Lauderdale, Shelby Tipton

Kim Hale, District Public Conservator
John Houmes, Assistant
B. J. Snipp, Assistant
Greater Nashville Regional Council
501 Union Street, 6th Floor
Nashville, TN 37219-1705
(615) 850-3922
FAX: (615) 862-8840

Counties: Cheatham, Davidson, Dickson, Houston, Humphreys, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, Wilson

APPENDIX 11-11

TENNESSEE BUREAU OF INVESTIGATIONS (TBI)

Medicaid Fraud Control Unit

SECTION 11-11
TENNESSEE BUREAU OF INVESTIGATIONS (TBI)
Medicaid Fraud Control Unit

DAVIDSON

SA Ramona Smith, Primary Abuse Investigator
SA Angela Beverly, Secondary Abuse Investigator
SA Richard Rogers
SA Bob Simmons

901 R. S. Gass Boulevard
Nashville, TN 37216-2639
Phone: (615) 744-4362
Fax: (615) 744-4659

Robert Schlafly, Special Agent-in-Charge
Norma Tidwell, Assistant Special Agent-in-Charge
Richard Camp, Managed Care Program Manager
Sandra Keifert, Staff Attorney
Valerie Smith, Staff Attorney
Sharon Matheny, Auditor
Brenda Williams, Auditor
Statistical Analyst:
Martha Batchelor, Nurse Investigator
Marsha Neuenschwander, Nurse Investigator
Frank Bryant, Computer Programmer
Liz Kubica, Computer Programmer
Dora Arnold, Administrative Secretary
Deborah Insignares, Administrative Secretary
Cindy Patterson, Administrative Secretary

HAMILTON

SA Scott Randolph, Primary Abuse Investigator
SA Kim Harmon, Secondary Abuse Investigator

State Office Building
540 McCallie Ave., Suite 650
Chattanooga, TN 37402-2085
Phone: (423) 634-3044
Fax: (423) 634-6003

KNOX

SA Margaret Chulinard,
Primary Abuse Investigator
SA T. J. Battle, Secondary Abuse Investigator
SA Andy Corbitt

4420 Whittle Springs Rd.,
Suite A
Knoxville, TN 37917
Phone: (865) 594-6510
Fax: (865) 594-6365

SECTION 11-11
TENNESSEE BUREAU OF INVESTIGATIONS (TBI)
Medicaid Fraud Control Unit
Con't

MADISON

Stephen Phelps, Assistant Special Agent-in-Charge
SA Terrill McLean, Primary Abuse Investigator
SA Doug Pate, Secondary Abuse Investigator
SA Glyn Whitworth

121 Executive Drive
Jackson, TN 38305
Phone: (731) 984-6666
Fax: (731) 668-9679

PUTNAM

SA David Moore, Primary Abuse Investigator
SA Billy Miller, Secondary Abuse Investigator

1519 East Spring St., Suite E.
Cookeville, TN 38501
Phone: (931) 526-5041
Fax: (931) 528-3291

SHELBY

SA Roger Turner, **Primary Abuse Investigator**
SA Joel Parker, Seconday Abuse Investigator
SA Terry Reed

6325 Haley Road
Memphis, TN 38134
Phone: (901) 379-3400
Fax: (901) 372-1218

WASHINGTON

SA Stanley Hodges, Primary Abuse Investigator
SA Barry Carrier, Secondary Abuse Investigator

207 N. Boone St., Ste. 600
Johnson City, TN 37604
Phone: (423) 434-6424
Fax: (423) 434-6437

SECTION 11-12
MENTAL HEALTH CRISIS TEAMS

CRISIS PROGRAMS

WEST TENNESSEE

1-800-353-9918
24/7 Mobile Crisis number for counties covered by **Quinco Mental Health Center**, **Carey Counseling Center** and **Professional Counseling Services***

Counties: Benton, Carroll, Chester, Decatur, Fayette, Gibson, Harden, Hardiman, Henry, Lauderdale, McNairy, Tipton

*Roger Chinery,
Crisis Program Director
Quinco Mental Health Center
10710 Old Highway 64
Route 1, Box 500
Bolivar, TN 38008
1-800-353-9918

*Paul Knolls,
Crisis Program Director
Carey Counseling Center
19410 West Main
P.O. Box 793
Huntington, TN 38344
1-800-353-9918

*Kathy Strahan, Crisis Program Director
Professional Counseling Services
1997 Highway 51 South
Covington, TN 38019
1-800-353-9918

Jimmy Jones,
Crisis Program Director
Pathway of Tennessee
238 Summar Drive
Jackson, TN 38301
(901) 935-8210
1-800-481-7730

Counties: Crockett, Dyer, Haywood, Henderson, Lake, Madison, Obion, Weakley

Rod Scott,
Crisis Program Director
Midtown Mental Health Center
427 Linden Avenue
Memphis TN 38126
(901) 577-0200
(901) 577-9400 24 hour crisis line

County: Shelby

MIDDLE TENNESSEE

Kristin Morrow,
Crisis Program Director
Centerstone
511 8th Street
Clarksville, TN 37040
(931) 920-7200
1-800-681-7444 24 hour crisis line

Counties: Cheatham, Dickson, Houston, Humphreys, Montgomery, Robertson, Stewart

Stephanie Holgate-Williams,
Crisis Program Director
Centerstone
1222 Medical Center Drive
Columbia, TN 38401
(931) 490-1500
1-800-681-7444

Counties: Giles, Hickman, Lawrence, Lewis, Marshall, Maury, Perry, Wayne

Daphne Yocum, Crisis Program Director
Centerstone
1803 North Jackson Street
Tullahoma, TN 37388
(931) 461-1300
1-800-681-7444

Counties: Bedford, Coffee, Franklin, Lincoln, Moore

Coneigh (prounounced "Connie") Seay,
Crisis Program Director
Cumberland Mental Health Center
1070 Old Highway North
Gallatin, TN 37066
(615) 452-1354
(615) 230-6333

Counties: Sumner, Trousdale, Wilson

Coneigh (prounounced "Connie") Seay,
Crisis Program Director
Guidance Center
2126 N. Thompson Lane
Murfreesboro, TN 37129
1-800-704-2651

Counties: Cannon, Rutherford, Williamson

Linda Whittemore,
Crisis Program Director
Tennessee Mental Health Cooperative
275 Cumberland Bend Drive
Nashville, TN 37228
(615) 726-0125

County: Davidson

EAST TENNESSEE

Mark Shively,
Crisis Program Director
Fortwood Center, Inc.
601 Cumberland Street
Chattanooga, TN 37404
(423) 266-6751 (office/Adult Svcs.)
(423) 634-8995 Crisis Line

County: (South of the River) Greater Chattanooga

Nancy Carroll,
Crisis Program Director
Johnson/Hiawassee Mental Health Center
413 Spring St.
Chattanooga, TN 37405
(423) 634-8884
(423) 634-8995 Crisis Line

Counties: (North of the River) Marion, McMinn, Meigs, Polk, Rhea, Sequatchie

Jody Bartlett,
Crisis Program Director
Plateau Mental Health Center
1200 So. Willow Ave.
Cookeville. TN 38506
(931) 432-4123
1-800-704-2651 Crisis Line

Counties: Clay, Cumberland, Dekalb, Fentress, Jackson, Macon Overton, Pickett, Putnam, Smith, Van Buren, Warren, White

Paul Hickling
Crisis Program Director
Nolachucky/Holston Area Mental Health Center
401 Holston Drive (temporary)
Greeneville, TN 37743
(423) 639-1104
1-877-928-9062 Crisis line

Counties: Greene, Hancock, Hawkins

Paul Hickling
Crisis Program Director
Watauga Area Mental Health Center
Woodridge Hospital
403 No. State Of Franklin Rd.
Johnson City, TN 37605
(423) 928-7111
1-800-346-8899
1-877-928-9062 Crisis Line

Counties: Carter, Johnson, Sullivan, Unicoi, Washington

EAST TENNESSEE CON'T

Mark Potts,
Crisis Program Director
Overlook Mental Health Center
6800 Baum Dr.
Knoxville, TN 37919
(865) 539-2409

Counties: Blount, Knox, Loudon, Monroe, Sevier

Sylvia Whaley
Crisis Program Director
Ridgeview Psychiatric Hospital
240 West Tyrone Rd.
Oak Ridge, TN 37830
(865) 482-1076
(865) 481-6175 Crisis Line

Counties: Anderson, Campbell, Morgan, Roane, Scott

Judy Havner,
Crisis Program Director
Cherokee Health systems
6350 W. Andrew Johnson Hwy.
Talbott, TN 37877
(423) 587-7337
1-800-826-6881 Crisis Line

Counties: Claiborne, Cocke, Grainger, Hamblen, Jefferson, Union

SECTION 11-13

APS RISK FACTORS

GUIDELINES FOR ASSESSING LEVELS OF RISK

Risk Factors are numbered to correspond to Sections of 817. When more than one risk factor applies to the same section, it is shown with a sub-number ((1), (2), (3) etc.)

Strength/Low Risk	Intermediate Risk	High Risk
2(1). Client's Physical Health/Ability to Perform ADLs		
Strength -No obvious physical disability; capable of meeting all ADLs. **Low** -Minimal physical disability; with appliance such as cane, hearing aid, eyeglasses, etc., is able to function independently. -Can meet most/essential ADLs without assistance	-Moderate physical disability requiring dependence on appliance -Difficulty ambulating; requires walker, wheelchair, etc. or hands-on assistance to be ambulatory. -Needs some assistance to meet essential ADLs. -Chronic illness, condition or injury that is not life threatening, but requires continuous treatment/care.	-Severe, functionally limiting disability. -Bedfast, completely dependent on others. -Chronic or acute potentially life-threatening illness, condition or injury. -Rapid deterioration of functional abilities. -Danger of irreparable loss of function/ability.
2(2). Client's Mental/Emotional Health/Ability to Perform ADLs		
Strength -No evidence of mental illness or disability **Low** -Minimal mental or emotional disability -Generally complies with treatment and/or medication, which control mental condition. -Performs most/essential ADLs	-Moderate mental retardation. -Periodic disorientation/confusion -Impaired reasoning ability. -Moderate mental illness, i.e. mild or moderate depression -Inconsistently complies with treatment, medication to control mental impairment -Inconsistent ability to meet ADLs. -Episodic alcohol/substance abuse.	-Severe or profound mental retardation. -Severe mental illness, (delusions, hallucinations) -Constant confusion/ disorientation. -Recent rapid deterioration of mental/emot. health/functioning. -Severe depression. -Suicidal ideation. -Does not comply with needed services or treatment. -Unable to meet essential ADLs due to mental status. -Any bizarre or violent behavior. Chronic alcohol/substance abuse.
4(1). Environmental Conditions: Structural Soundness/Safety of Home		
Strength -Sound structure with no apparent safety problems. **Low** -Minor structural problems that pose no safety hazard, such as needing paint, minor repairs to roof or exterior. -Water, heat and other utilities are in working order most of the time, with no threat to personal safety.	-Deteriorating structure or safety problem posing some degree of risk such as leaking roof, broken windows, exposed wiring, etc. -Overgrown yard. -Some utilities are shut off but are currently unnecessary due to weather conditions, or other substitutes are in place.	-Home is hazardous, dilapidated, poses an immediate and continuing threat. -Home is dangerously unsafe, condemned or barely suitable for providing shelter. -No utilities are available or functioning, and no plan exists to reinstate them. -Broken windows, leaks, holes in walls, floor or roof in inclement and/or cold weather. -Fire hazards. -Eviction pending, or client without reliable shelter.

Strength/Low Risk	Intermediate Risk	High Risk
4(2). Environmental Conditions: Housing Appropriate for Client's Needs		
Strength -Residence does not contribute to client's risk; heating and cooling are adequate for client's needs. -All areas of home are accessible to client. **Low** -Non-essential area of home, such as a spare bedroom, not easily accessible to client -Home is slightly overcrowded; some lack of privacy, members of household may share average bedroom space.	-Residence poses special problems that place client at risk, i.e., client wanders and lives near major highway, home is in high crime area. -Client cannot easily access food preparation, toilet, bathing areas, or operate equipment.	-Residence poses special problems that place client at immediate risk, e.g., client cannot operate type of heating or cooking equipment, such as wood-burning stove, or absence of heating/ cooking source, home has stairs or other barriers preventing client from having access to bathing, toilet, food preparation areas. -Client repeatedly victimized by violent crime. -Living/sleeping arrangements pose threat to safety.
4(3). Environmental Conditions: Cleanliness/Health Conditions of Home		
Strength -Home is well maintained, housekeeping is adequate. -There are no serious health issues, trash not exposed, no odors present **Low** -Minor housekeeping or health issues, i.e. garbage or trash container exposed or overflowing, accumulation of dirty dishes or other housekeeping issues.	-Trash and garbage in/around house. -Odors indicating decaying matter. -Toilets/plumbing operating poorly. -Pet droppings in home cleaned irregularly. -Some evidence of pest infestation. -Some evidence of excessive accumulation of objects, trash, personal belongings, etc.	-Accumulated trash or garbage in home. -Severe pest/rodent infestation Human and/or animal waste is present -Sewage or other health code violations -Toilets, plumbing for waste disposal not operating. -Absence of refrigeration or proper food storage -Accumulation of trash, personal belongings, objects, pets, etc. that put client in danger.
5. Financial Resources		
Strength -Client has income and resources adequate to meet needs; client manages own funds competently. **Low** -Client has income and resources sufficient to meet most or essential needs. -May sometimes need assistance with money management	-Marginal financial resources, barely able to provide necessities, must sometimes choose between necessities, e.g. non-prescription medicine vs. food. -Client dependent on others for income, needs met inconsistently. -Client receives assistance with managing funds from others whose reliability varies. -Client has sufficient funds but standard of living is not consistent with level of resources.	-Client totally depends upon others financially. -Regardless of income, client unable or unwilling to spend for necessities. -Client unaware of finances, bills unpaid, checks uncashed, money lost or misplaced. -Client giving money away, basic needs unmet. -Depleted funds, questionable reason. -Client's money being taken, or misused. -Inadequate funds for necessary expenses.

Strength/Low Risk	Intermediate Risk	High Risk
6(1). Severity/Frequency of Exploitation		
Strength -No misuse of funds, funds used for client's benefit only. **Low** -Funds improperly used, poorly managed or diverted with little or no impact on the client's health or safety	-A pattern of on-going exploitation which, if unchecked, could threaten the client's health, safety or well-being -Client's minimal needs for food and medicines are being met, but bills are not consistently paid, utilities cut off sporadically with no significant impact on client's safety.	-Any systematic misuse of client's funds by fraud or forgery. -Misuse or mismanagement of funds that results in the client's being deprived of food, shelter, medication, utilities or any other necessities for life, health or safety.
6(2). Severity/Frequency of Self-Neglect		
Strength -Client is well-informed, responsible, performs all ADLs, independently accesses resources and obtains needed assistance **Low** -Client meets own minimal needs for survival, i.e. food, shelter, essential medical care, etc.	-Client consistently meets minimal needs for survival, i.e. food, shelter and essential medical care, but knowledge, skills, capability or degree of responsibility are problematic. -Client seeks medical treatment but fails to follow through with doctor's orders, allows prolonged time to elapse between injury/illness and seeking medical attention. -Client needs in-home services to safely maintain independent living, i.e. homemaker, Home Health, etc. -Client performs essential ADLs, but dresses inappropriately for weather, does not obtain needed hearing aid, glasses, etc. -Client is reluctant to admit to unmet needs or to accept services.	-Client is at risk of imminent harm from self-neglect due to impaired judgment or lack of knowledge or skills needed to perform ADLs. -Client lives alone and has diminished mental and/or physical capacity. -Client is unable physically and/or mentally to perform ADLs or access resources, and has no one able and/or willing who will provide needed assistance. -Client is unable to understand the problems and consequences of unmet essential needs. -Client denies that there is any problem with safety and/or performing essential activities. -Client resists or refuses critically needed assistance/services.
6(3). Severity/Frequency of Physical/Sexual/Psychological Abuse		
Strength -No physical, sexual or psychological abuse. **Low** -Incidents limited to verbal abuse with no apparent long-term adverse psychological effect on client.	-Unexplained or admittedly inflicted minor injury. -Pattern of increasing severity/frequency of minor injuries.	-Any non-consensual sexual activity or contact. -Any injury to head, face or genitals. -Any injury which warrants medical treatment or hospitalization. -Pattern of serious injury. -Client evidences serious adverse psychological effects of abuse. -Improper or excessive restraint or confinement. -Client is traumatized due to physical or emotional isolation.

Strength/Low Risk	Intermediate Risk	High Risk
6(4). Severity/Frequency of Neglect		
Strength -No allegations of neglect, no observable evidence of neglect. **Low** -Isolated, explainable incident of neglect, such as being late with meals or medication, but which does not create substantial risk	-Lack of adequate supervision or basic needs, i.e. medical care/appliances, food, shelter, etc., which, if uncorrected, would endanger the health and safety of the client. -Caregiver is inconsistent in meeting minimum needs. -Needed glasses, hearing aid, dentures, or other appliances being withheld or not provided.	-Client requires immediate intervention, i.e., medical treatment, placement, emergency services etc., to prevent risk of death, serious or irreparable harm due to lack of supervision or care. -Client is physically, mentally or emotionally traumatized due to lack of care. -Client needing supervision left alone, wandering. -Needed assistance with ADLs is lacking.
6(5). Client's Previous History of Victimization: Violence, Maltreatment or Self-Neglect		
Strength -Client has no known history of self-neglect or as a victim of violence or maltreatment. **Low** -Previous reports or history of minor incidents of neglect that represented low risk, i.e., that left no physical or emotional injury and did not place the client in immediate danger.	-Several previous reports that are increasing in frequency or severity. -One previous valid report of physical or emotional injury. -One previous valid report of neglect that placed the client in immediate danger. -A previous report in which the investigation could not be completed, i.e., the client could not be located, etc.	-A previous valid report of a serious nature. -Multiple reports of maltreatment involving the client, family and/or the perpetrator. -Client's prior history of being moved to prevent contact by the agency. -Ongoing history or pattern of increasing frequency or severity of self-neglect, violence or maltreatment. -Any previous report that led to prosecution.
6(6). Perpetrator's Access to Client Applies only to abuse and exploitation		
Strength -Perpetrator is not in the home, client is adequately protected from any further contact with perpetrator. **Low** -Perpetrator has very limited access to client under supervised conditions; other protective adult is present in the home.	-Unpredictable or inconsistent presence of others in the home. -Non-perpetrator adult present in the home, but ability to provide protection is questionable. -Limited opportunity for perpetrator to be alone with client.	-Perpetrator(s) has (have) unrestricted access to client. -Non-perpetrator adult does not believe that maltreatment occurred and is unlikely to restrict access. -No other adult resides in the home.

Strength/Low Risk	Intermediate Risk	High Risk
7(1). Support Systems: Availability of and Access to Services		
Strength -Adequate services readily available in community, client has regular transportation, or services are provided in the home. -Client accepts services. **Low** -Needed services are available, but with short-term waiting list—plan for emergency provision is in place.	-Limited community services available, or short-term waiting list. -Effectiveness/reliability of service is problematic. -Public transportation unavailable, private transportation problematic. -Client resists services.	-Needed services lacking, ineffective or have long waiting list. -Client geographically isolated, or transportation unavailable or inaccessible for client. -Client refuses needed services.
7(2). Support Systems: Availability of Family, Friends and Others		
Strength -Family, friends, neighbors able and willing to assist with providing or accessing needed services for client, i.e., transportation, shopping, home maintenance, etc. **Low** -Family, friends, neighbors able and willing to assist but have limited knowledge of resources.	-Family, friends somewhat supportive, but not geographically available. -Limited support from family, friends, neighbors, support is irregular in quality or frequency. -Family, friends willing to provide support, but require external/agency direction/involvement.	-Client socially, emotionally isolated, no one available, willing or able to assist. -Friends, family lack knowledge of resources or skill to acquire information. -Family, friends, stressed by caregiving or other responsibilities, unable or unwilling to provide needed assistance. -Strained relationships among family members, friends, erect barriers to providing support to client. -Client physically, geographically isolated, seldom seen by others. -Client isolated by language or cultural barriers.

Strength/Low Risk	Intermediate Risk	High Risk

7(3). Client's Presenting Behaviors Contribution to Caregiver Stress (i.e., substance misuse, wandering, verbal abuse, etc.)

Strength
-Client is generally compliant, rational and cooperative with care.
-Client is in possession of mental faculties and presents no management problem.
-Client has no history of substance misuse, mental illness, wandering, criminal behavior, etc.

Low
-Client has isolated, minor episodes of alcohol use without significant impact on behavior or compliance.
-Client has episodes of minor depression, lack of compliance with treatment, but responds to caregiver persuasion
-Client expresses reluctance to cooperate with treatment, but is physically/behaviorally compliant.

-Client has periodic episodes of alcohol/drug misuse, and is non-compliant with treatment during these times.
-Client has periodic episodes of being disoriented, uncooperative with some management difficulty.
-Client has had episodes of wandering, but stays close to home without incurring significant risk.
-Client has periodic episodes of being irritable, fussy, unreasonably demanding.

-Client is active alcohol/substance abuser.
-Client is verbally abusive to others.
-Client is combative, disruptive, violent or otherwise provocative.
-Client actively refuses to cooperate with attempts to provide care.
-Client is generally irrational, non-compliant and /or disoriented.
-Client regularly engages in wandering behavior which creates risk, such as wandering into heavy traffic, out in inclement weather with inadequate
clothing or unsafe areas.
-Client's behavior represents a danger to self or others.
-Client is unduly critical

7(4). Caregiver's Cooperation with Agency

Strength
-Caregiver is aware of or immediately believes there is a problem and cooperates to resolve the problem and protect the client.
-Caregiver is fully and actively involved in case planning and services.
-Caregiver takes the initiative, complains about inadequate services when warranted.
-Caregiver may not agree with every service suggestion, but constructively offers alternatives.

Low
-Caregiver makes a commitment to cooperate, but does so reluctantly.
-Caregiver denies some responsibility, but admits there is a problem.
-Caregiver is not as fully involved in the case planning as could be.
-Caregiver accepts and adheres to most service tasks/objectives but may not make optimum use of available services.

-Caregiver accepts services passively, resists cooperating, is argumentative at every stage.
-Caregiver shows little concern or remorse about the maltreatment or client's welfare.
-Caregiver's involvement or participation is obtained only by constant prodding or direct assistance.
-Caregiver attempts to manipulate agency and service providers.
-Agency and service providers have difficulty maintaining contact with client because caregiver makes a concerted effort to prevent monitoring, reluctantly allows privacy to interview client, is not at home when services are scheduled.

-Despite evidence, caregiver doesn't believe there is a problem, refuses to cooperate at every stage of case planning.
-Caregiver actively sabotages all service tasks/plans.
-Caregiver is very difficult to contact, therefore it is difficult to assess caregiver's cooperation on a regularly scheduled basis.
-Caregiver is openly defiant, refuses to cooperate or allow service provision.
-Caregiver has history of physically moving an adult to prevent or hinder investigation or service provision.
-Caregiver's cooperation is obtained only by court order.

Strength/Low Risk	Intermediate Risk	High Risk
7(5). Caregiver's Physical Health		
Strength -Caregiver has no observable illness or physical limitation that affects the ability to provide adequate care. **Low** -Caregiver has minor illness or physical disability causing some erratic care of client. -Caregiver has minor illness or physical disability that requires some services or assistance to enable her/him to provide care.	-Caregiver appears to have a physical illness or condition that significantly interferes with the ability to provide adequate care, i.e. caregiver's arthritis causes meals to be late on a regular basis, which poses a risk for client who is diabetic. -Caregiver has a reported illness that is untreated or deteriorating to the point that supplementary services must be provided to ensure adequate care. -Caregiver has a poorly controlled or compensated illness that could improve with treatment.	*Caregiver has an illness or condition that severely impairs caretaking capacity. *Caregiver appears preoccupied with own physical health, is capable of little more than self-care, and it appears that no immediate improvement is likely, even with treatment. *Caregiver has experienced a recent and rapid deterioration in physical health. *Caregiver has a serious communicable disease that poses a health threat to the client.
7(6). Caregiver's Mental Health		
Strength -Caregiver has no observable intellectual limitation or evidence of mental or emotional disability. **Low** -Caregiver has minimal, controlled or compensated mental condition or limitation. -Minor developmental limitation or mental illness which, with currently existing supports, does not inhibit adequate care of the client.	-Caregiver experiences periodic mental difficulties. -Caregiver is immature, dependent or has unrealistic expectations. -Caregiver is somewhat unresponsive to the client. -Caregiver has an intellectual limitation that affects ability to provide care and protection.	-Caregiver has history of chronic or uncontrolled mental illness. *Caregiver has severe and functionally limiting mental disability. -Caregiver appears preoccupied with own mental or emotional problems. -Caregiver demonstrates poor reasoning ability, poor conception or lack of reality. -Caregiver demonstrates desire to harm the client, asks to be relieved of client's care or threatens the client with hospitalization/institutionalization or eviction. *Caregiver demonstrates bizarre, violent or suicidal behavior. *Caregiver has had recent rapid deterioration of mental/emotional health/control.

*If caregiver exhibits these characteristics, consider assessing the caregiver's need for APS.

Strength/Low Risk	Intermediate Risk	High Risk

7(7). Caregiver's Misuse of Alcohol/Drugs

Strength/Low Risk	Intermediate Risk	High Risk
Strength -No evidence or history of substance misuse or dependency. -Former substance abuser has successfully completed a recognized treatment program and appears to be providing risk-free care for the client. **Low** -Caregiver consumes alcohol only in moderation and is not out of control or subject to any changes in capabilities when drinking.	-Caregiver is experimenting with or using alcohol/drugs, but excessive use tends to be episodic. -Pattern of substance/alcohol misuses or dependency is escalating. -Caregiver admits to substance misuses and is reluctant to seek treatment. -Caregiver is periodically incapable of providing care due to substance misuse, and ability to make or ensure alternate care arrangements is deteriorating.	-Caregiver's substance misuse negatively affects ability to provide care and ensure client's basic needs are met, including depleting finances. -Caregiver's life revolves around the use of or obtaining alcohol or drugs. -Caregiver refuses treatment or is a chronic treatment dropout.

7(8). Caregiver's Knowledge of Caregiving and Realistic Expectations of Client's Abilities

Strength/Low Risk	Intermediate Risk	High Risk
Strength -Caregiver's level of care is adequate for the client's needs. -Caregiver's response to the client's dependency behaviors demonstrates understanding and acceptance of the client's needs and capabilities. **Low** -Caregiver is generally consistent with meeting client's needs, only occasionally expresses irritation or impatience by mild verbal behavior. -Caregiver's level of care may occasionally not be adequate for client's special needs, but unrealistic expectations do not pose any immediate risk to client's safety or welfare. -Caregiver's unrealistic expectations err on the side of being overly protective or solicitous of client.	-Caregiver's level of care or supervision places the client at some risk, such as leaving bedbound client in home alone for several hours, but client has never actually been harmed. -Caregiver's verbal response to client's dependence is inappropriate, demanding. -Caregiver demonstrates poor knowledge of client's needs and abilities, by making demands of the client that frustrate both client and caregiver. -Caregiver is inconsistent in responding to client for basic needs. -Caregiver has expressed or demonstrated difficulty in meeting client's minimum medical, emotional, food, clothing or shelter needs. -Caregiver sometimes personalizes client's demands/behaviors.	-Caregiver's level of care or plan has repeatedly exposed the client to danger, and caregiver refuses to develop/implement corrective measures. -Caregiver responds to client's behavior/dependency needs with physical measures inappropriate for use with an adult, i.e., spanking, punitive restraint. -Caregiver's use of harsh, curt verbal responses is escalating in frequency and/or harshness. -Caregiver demonstrates poor understanding of the client's needs and capabilities, resulting in unrealistic demands most of the time. -Caregiver labels the client's behavior as "bad", expresses or demonstrates belief that the client needs discipline or punishment. -Caregiver routinely personalizes client's behavior, dependency needs as being intentional, meant to thwart or manipulate.

Strength/Low Risk	Intermediate Risk	High Risk

7(9). Caregiver's Financial Dependence on Client

Strength -Caregiver has sufficient income to meet own needs, is totally financially independent of client. **Low** -Caregiver is only occasionally, or minimally dependent on client for financial assistance, and there is no evidence of resentment from either caregiver or client.	-Caregiver feels obligated to care for client because of financial necessity. -Client provides ongoing partial or supplementary support to caregiver, and there is some indication of exploitative behavior, or resentment from client or caregiver.	-Caregiver is largely or totally financially dependent on client. -Caregiver exhibits or expresses resentment of needing to rely on client for financial assistance.

7(10). Client/Caregiver/Family Dynamics

Strength -Normal amicable relationships between client and caregiver/family members. -Caregiver/family members realistically adapt and adjust to situational stress without overreacting or disrupting relationships. -No apparent special problems. -Family members agree on division of responsibilities and roles. **Low** -Client and caregiver have had minor conflicts that are usually short-term and are easily resolved. -In the past year, family has experienced some stressors, i.e. financial problems, birth, divorce, death, martial/family problems, illness, etc., but has adjusted and is currently functioning in a stable manner. -Family members usually agree on division of roles and responsibilities in providing care for client.	-Client makes excuses for or otherwise acts to protect the perpetrator, appears to be excessively loyal to caregiver/perpetrator. -Client expresses self-blaming, quilt, shame, or appears stoic regarding abuse/neglect. -Caregiver/family have difficult, prolonged inappropriate or unrealistic response/adjustment to situational stress/life crises, i.e. prolonged or excessive frustration, fatigue, depression, anger, etc. -Client and caregiver have ongoing interpersonal conflicts expressed verbally. -Within the last year, the family has had to deal with numerous stressors that have adversely affected the client's care and safety. -Marital conflicts among family members or between client and spouse. -Caregiver isolated, with no contacts outside of the home. -Interaction between client and caregiver is frequently conflictive or disruptive.	-Client demonstrates fear of caregiver or family member. -Client or caregiver tolerates abuse/neglect due to emotional dependence on or bond with perpetrator. -Client or caregiver looks to perpetrator for answers. -Caregiver/family have gross overreaction to stress/crises, i.e. hopelessness, severe depression. -Family is in a constant state of crisis due to stress, or seems to thrive on a chaotic lifestyle. -Client and caregiver have history of intergenerational conflict, i.e. abuse of caregiver as a child. -Any history of caregiver/family using violence to handle conflict or stress. -Ongoing significant disagreement among family members over sharing responsibility for client's care and safety. -Interaction between client and caregiver is extremely disruptive, violent or unpredictable.

APPENDIX 11-14

Memorandum of Understanding

Tennessee Department of Human Services

and

Tennessee Department of Mental Health and Developmental Disabilities

MEMORANDUM OF UNDERSTANDING

Tennessee Department of Human Services and
Tennessee Department of Mental Health and Mental Retardation for
Investigations Within Facilities of the
Tennessee Department of Mental Health and Mental Retardation

The Tennessee Adult Protection Act (T.C.A. 71-6-101 et seq.) is administered by Tennessee Department of Human Services (TDHS) and provides protection to clients receiving services within facilities operated by the Tennessee Department of Mental Health and Mental Retardation (TDMHMR). Each agency has the responsibility to investigate harmful conditions. In order to efficiently and effectively discharge their duties, TDHS and TDMHMR have formalized the following method of cooperation. This agreement applies to investigations in the following locations when operated by the state: Memphis Mental Health Institute, Western Mental Health Institute. Middle Tennessee Mental Health Institute, Lakeshore Mental Health Institute, Moccasin Bend Mental Health Institute. Arlington Developmental Center, Nat T. Winston Developmental Center, Clover Bottom Developmental Center, and Greene Valley Developmental Center.

The Tennessee Department of Human Services/Adult Protective Services **(TDHS/APS)** has the following responsibilities:

> *Receive and investigate reports of abuse, neglect or exploitation of adults; notify law enforcement and the licensing authority upon receipt of the referral; interview the client; determine the risks to the adult and provide appropriate intervention, maintain confidential records; and notify the referent of the results of the investigation after the investigation and assessment process has been completed.*

The Tennessee Department of Mental Health and Mental Retardation (TDMHMR) has the following responsibilities:

> Report to *TDHS/APS and other appropriate authorities, allegations of abuse, neglect, mistreatment, and exploitation; investigate suspected abuse, neglect, and mistreatment; protect patients from harm through appropriate interventions, maintain records on the investigations, cooperate with TDHS/APS staff in completing investigations.*

In order to meat these responsibilities, each agency, as noted, agrees to the following:

1. TDHS

TDHS/APS has four (4) intake sites which are staffed during regular office hours and can record voice mail messages on a 24 hour a day basis. Messages are retrieved and responded to 8:00 A.M. - 4:30 P.M., Monday-Friday.

A. TDHS/APS - Appropriate Referrals

TDHS/APS staff will receive and accept appropriate TDHS/APS referrals. Appropriate referrals are those which allege abuse, neglect or exploitation of specific adults and meet the definitions below:

Adult - A person eighteen (18) years of age or older who because of mental or physical dysfunctioning or advanced age is unable to manage his/her own resources, carry out the activities of daily living, or protect her/himself from neglect, hazardous or abusive situations without assistance from others and who has no available, willing, and responsibly able person to assist him/her and may be in need of protective services.

Abuse - Acts which cause physical pain, physical injury, mental anguish. emotional trauma or unreasonable confinement.

Sexual Abuse - An adult is forced, tricked, threatened or otherwise coerced into sexual activity, involuntary exposure to sexually explicit material or language, or sexual contact against his/her will. Sexual abuse also occurs when an adult is unable to give consent to such activities or contact and is engaged in such activities or contact with another person.

Neglect - The omission of services/care needed by an adult in order to prevent physical or mental injury/illness, i.e., withholding of medical care, food. shelter, or clothing necessary to protect the adult's health.

Exploitation • Improper use by a caretaker of funds which have been paid by a governmental agency to an adult or to the caretaker for the use or care of the adult.

B. TDHS/APS • Inappropriate Referrals

Inappropriate TDHS/APS referrals are those alleging general complaints regarding the operation of or the care provided within the facility, i.e.. unsanitary conditions, dirty linen or cold food which do not pose an immediate risk to the client. Such conditions may be in violation of facility standards but may not be of such a nature or degree as to warrant a referral for an TDHS/APS investigation.

2. SHARING REFERRALS BETWEEN TDHS/APS AND TDMHMR

All referrals of abuse, neglect or exploitation of adults in TDMHMR facilities reported to TDHS/APS will be provided to the superintendent of the appropriate TDMHMR facility. Exception: referrals which include allegations involving the superintendent or the investigator as a part of the complaint will not be reported to the superintendent, but will be reported directly to the Assistant Commissioner of Mental Health or Mental Retardation Services. All appropriate referrals known to the TDMHMR will be reported to the respective TDHS/APS Intake Office. TDMHMR will report to the intake site, referrals appropriate to the geographical area as indicated by TDHS/APS.

***All referrals should go to the nearest urban office, if it is not long* distance for the caller.**

Knoxville: (865) 594-5685
Chattanooga: (423) 634-6624
Nashville: (615) 532-3492
Shelby: (901) 543-7800

When outside the urban calling area use the TDHS/APS statewide toll free number: 1-888-APS-TENN
(1-888-277-8366)

A. TDMHMR Reports to TDHS/APS

Upon receipt of a complaint of alleged abuse, neglect, mistreatment, or exploitation, it is the responsibility of the TDMHMR facility superintendent to immediately notify *"the appropriate geographical site",* as specified above, regarding the nature of the complaint. If TDHS/APS staff are not available, a message will be left on the TDHS/APS voice mail giving the calling party's name, telephone number, where the caller can be reached and the nature of the call. Investigations by TDMHMR will not be delayed by the availability or unavailability of TDHS/APS staff through telephone contact.

B. TDMHMR Response to TDHS Reports

TDMHMR will respond in accordance with its investigations policy. In general this response will be as follows:

1. Emergency Referrals

When the referral includes allegations of: 1) physical abuse; 2) sexual abuse; 3) serious or unexplained injury; 4) death or physical injury requiring treatment by a physician, the investigation by TDMHMR will be initiated within one hour upon receipt of the referral.

2. Non-Emergency Referrals

When the referral involves a non-emergency allegation, the investigation by TDMHMR will be initiated by the next working day.

C. TDHS/APS Response to Reports

TDHS/APS will accept appropriate reports of abuse, neglect, or exploitation from any person. However, TDMHMR has identified the TDMHMR facility superintendent as responsible for reporting for each TDMHMR facility.

1. Emergency Referrals

When the referral includes allegations of: 1) serious illness; 2) abuse which is occurring at the time of the referral; 3) sexual or physical abuse with the alleged perpetrator having access to the victim; 4) an incident of sexual abuse which has occurred within the past seventy-two (72) hours; 5) visible injuries or possible life threatening conditions, the investigation by TDHS/APS will be initiated on the day the referral is received and accepted by TDHS/APS.

2. Non-Emergency Referrals

When the referral involves a non-emergency allegation, the investigation by TDHS/APS will be initiated within five (5) working days after being accepted by TDHS/APS.

3. INVESTIGATIONS

Whenever possible, investigations conducted jointly by TDMHMR and TDHS/APS are encouraged and supported. There will, however, be times when separate investigations are warranted but this will be determined on a case-by-case basis and be agreed upon by both agency investigators. Each agency reserves the right to conduct separate investigations at any time. When conducting separate or joint investigations, each agency will share information relevant to the investigation during the investigation process including requested copies but excluding preliminary materials created by the investigator,

A. Interviews

1. Initiation of the TDHS/APS investigation will begin by contact by TDHS/APS -staff with the facility superintendent or his/her designee. Exceptions may be made at the discretion of the investigating staff.
2. The TDHS/APS client must always be seen and interviewed by an TDHS/APS counselor. Some clients will not be able to communicate with the TDHS/APS Counselor, but all reasonable efforts will be made to communicate with and observe the client.
3. Any person believed to have information which will assist in determining the client's condition, risk and need for services may be interviewed. This may include physicians, nurses, social workers, family members, other patients, aides, etc. If consultation or a medical opinion is needed, in order to complete the investigation, the superintendent may be contacted and assistance requested in obtaining an evaluation or examination of the client

B. Limited Investigations

When TDHS/APS initiates an investigation after TDMHMR has completed its investigation and taken action to protect the client, then TDHS/APS may choose to do a limited investigation which will include review of the TDMHMR investigative file and report, interview with the client, and when feasible, interview with the alleged perpetrator. If TDHS/APS believes appropriate action has been taken to protect the client, then further involvement by TDHS/APS may not be necessary. If there are any remaining issues or concerns, TDHS/APS will continue their investigation to resolve any of these issues or concerns.

C. Access to Records - TDHS/APS

Any TDHS/APS representative who is actively involved in the conduct of an investigation shall be allowed access to the mental and physical health records of the client which are in the possession of the TDMHMR staff or facility. In addition, TDHS/APS will have access to any other relevant records, including but not limited to personnel, staffing pattern, work schedules, and personnel history, any of which are necessary to complete the investigation. Drug and alcohol treatment records may not be released except by a court order or a release signed by the patient. Therefore these records will not be shared with TDHS/APS unless a court order or release is provided. Questions concerning the legality of records release should be referred to legal counsel.

D. Investigative Reports

1. TDMHMR Responsibility

The final investigative report of TDMHMR will include but not be limited to: what happened to the client and the client's resulting condition, individuals interviewed, any medical reports and photographs related to the client, and actions taken by the facility to protect the client, and will apply the definitions of abuse, neglect, mistreatment, and exploitation provided by the TDMHMR statute and rules. The final report shall be forwarded to TDHS/APS within thirty (30) days of receipt by the TDMHMR investigations coordinator. This report is considered final even when a grievance is subsequently filed. TDMHMR will provide further notice of any personnel action overturned as a result of the grievance.

2. TDHS/APS Responsibility

Correspondence will be sent to the TDMHMR superintendent stating the determination by TDHS/APS of the status of the client's need for protection with a copy to the TDMHMR investigator at that facility. This letter will be sent within thirty (30) days of the completion of the TDHS/APS investigation. The correspondence will include the case assessment.

E. Conclusion of Investigations

Either department, upon receiving the final report of the other, will administratively close its investigation twenty-one (21) days after receipt of that report. If the receiving department desires to continue the investigation, it may notify the other that the investigation will continue.

4. ACTION TO PROTECT THE CLIENT

A. TDMHMR Responsibility

Upon receiving a complaint, the TDMHMR investigator will ensure that the client is protected from abuse, neglect, and mistreatment. If the investigator is unable to protect the client, then assistance should be requested from the facility superintendent. If the facility is unable to protect the client, then the investigator should request assistance from the TDMHMR Commissioner. TDMHMR shall have standing under T.C.A. 71-6-103(k)(1) to petition the court.

B. TDHS/APS Responsibility

If TDHS/APS determines that an adult who is a client of a facility owned or operated by TDMHMR is in need of protective services, and the facility is unable or unwilling to take action to protect the client, TDHS/APS shall make a report of its investigation, along with any recommendations for needed services to the commissioner of TDMHMR. It shall then be the responsibility of the TDMHMR Commissioner and not TDHS to take such steps as may be necessary to protect the adult from abuse, neglect, or exploitation as stated in T.C.A. 71-6-103(k)(1).

5. GENERAL PROVISIONS

A. Additional Notifications

All additional notifications will be made in accordance with the mandatory reporting requirement policies and statutes of each agency.

B. Confidentiality

1. If TDHS/APS obtains any information from TDMHMR in the course of its investigation, the confidentiality of which is protected by statute, TDHS/APS may not make use of or disclose such information except insofar as may be necessary to carry out the provisions of the Tennessee Adult Protection Act or as may be authorized by the statute establishing confidentiality. (T.C.A. 71-6-103G))

2. TDHS/APS is prohibited from releasing the identity of the person who reports abuse, neglect or exploitation. Therefore/this information will not be shared with TDMHMR. (T.C.A. 71-6-118)

3. Drug and alcohol treatment records may not be released except by a court order or release signed by the patient. Therefore, these records will not be shared with TDHS/APS unless a court order or release is provided.

C. Modification of Agreement

This agreement may be modified in whole or in part by written agreement of the commissioner of TDMHMR and the commissioner of TDHS. TDMHMR and TDHS, by signing this agreement, indicate their intent to abide by its terms until such time as the terms are modified.

D. Staff Training

Each department will share, with appropriate staff, the understanding reached in this memorandum.

E. Effective Date

This agreement becomes effective thirty (30) days from the date of the latest entry when all required signatures have been obtained.

Linda Rudolph, Commissioner Department of Human Services	Date 5-30-97
Ben Dishman, Acting Commissioner Department of Mental health and Mental Retardation	Date 5-21-97
John D. Ferguson, Commissioner Department of Finance and Administration	Date 6-4-97

INTERSTATE SERVICES

INTERSTATE SERVICES

While working with an adult in a protective services situation, it may be necessary to make contact with a family member or other resource in another state. Since there is no interstate agreement covering adults, contacts of this type should be carried out directly with the individual or the appropriate agency in the other state.

An inquiry from another state on behalf of an adult who is not receiving or is not eligible to receive Adult Protective Services should be handled as we handle other calls not meeting the criteria for APS. If we are aware of a resource that could assist the caller, we share that information. Information regarding the call is documented and filed as an I & R.

If you receive an inquiry on behalf of an adult in another state and that adult is receiving Adult Protective Services or would meet the criteria for services under our Adult Protection Act, efforts to comply with the request may be carried out under Interstate Services. Contacts may be made directly with the agency in the other state. Requests are only accepted if they come through the APS agency in the other state.

While there is no legal obligation for staff to respond to an inquiry of this nature, we respond to such inquiries as a courtesy. Our cooperation is related to our potential need for similar assistance from them on other case situations. If a written response is requested, APS staff provide only factual information, documenting only what was observed or what we were told. TN APS does not make formal recommendations.

A request from out of state that is accepted for services is marked as Interstate Services on the input document for ACSS data entry.

If a person is already here and is alleged to be abused or neglected, the request is handled as an APS case.

Questions regarding the appropriateness of a request from out of state may be directed to Adult Protective Services, State Office through supervisory channels.

Referrals from out of state requesting mental health or mental retardation services should not be accepted for Adult Protective Services, but should instead be directed to the Tennessee Department of Mental Health and Mental Retardation (TDMH/MR). TDMH/MR participates in an interstate compact with regard to mental health and mental retardation services.

Requests from out of state involving services for individuals with mental retardation should be directed to the Regional Offices of Community Services and the Developmental Centers Division of Mental Retardation Services. Interstate placement to and from mental facilities are handled under the Interstate Compact on Mental Health and should be coordinated through the Department of Mental Health.

SECTION 14 - HEALTH AND SAFETY

14-01 PHYSICAL SAFETY

In the performance of the job, APS staff frequently encounter clients and their families who are in crisis situations, who may become angry or hostile. Most individuals do not present a danger to the counselor. However, the counselor can use strategies and techniques to help defuse anger and hostility and enhance the working relationship. There can also be some instances in which individuals or situations may pose a physical threat. Following are guidelines and indicators to help:

- deal effectively with crises and hostility
- take reasonable steps to defuse volatile situations and maximize safety, and
- recognize signs and signals for immediately leaving the premises

14-01-01 General Safety Precautions

Following are some practices for general safety which staff should routinely follow when going into the field.

- In addition to signing out, inform someone in your office of where you are going and what time you expect to return.
- If you are uncomfortable about the visit or anticipate problems, discuss the situation with your supervisor. If feasible, ask a co-worker to accompany you.
- Be aware of your surroundings; identify “safe spots” in the area.
- Look around before getting in or out of your car.
- Lock your car doors while driving and when you leave your car.
- Lock valuables such as wallet and purse in the trunk.
- While walking to your car, have your keys ready in your hand. Avoid looking down or digging in your purse while walking.
- Make sure you have plenty of gas to get to your destination(s) and back.
- Ask for clear, specific directions before you leave.

14-01-02 **Threatening Situations**

When coming into an unknown or questionable situation:

- Scan the surroundings to establish the location of exits, etc.

- Sit or stand in a position where your back is to the door and there is no other person between you and the exit—facing the door usually means that you are facing another person who will be between you and the door.

- Sit or stand so that you do not invade the other person's personal space:
    - *Personal space* is the area around a person's body into which others may not come—intrusion into that space increases anxiety and may be perceived as threatening;
    - It varies from person to person, with the relationship between individuals at a given time and is influenced by culture and socialization;
    - The APS counselor will need to adapt to the other person's personal space, especially if it is a greater distance than that of the counselor, i.e., if the person moves back, allow the greater distance and do not move closer.

- APS intervention may stir strong feelings of fear, anger, etc. Some individuals may respond by verbally venting. Anger may escalate to the point of shouting or swearing. While this may be very uncomfortable for the counselor, most persons will experience a release of tension if allowed to vent, and will then return to rational thought. If the person being interviewed becomes loud, argumentative, sounds angry:
    - Do not attempt to respond to the outburst until it has subsided. Individuals that are yelling, etc. cannot hear nor can they think rationally. Interrupting to respond may aggravate the individual more and escalate the situation. Wait until the individual has quieted down before attempting to respond. It is of utmost importance to respond non-defensively.
    - <u>Do</u>
        - keep calm and maintain a lower voice volume
        - be aware of your body language and non-verbal message
        - observe the other person's body language and non-verbal behavior
        - allow the speaker to vent and show you are actively listening

- acknowledge the speaker's feelings
- remain respectful toward the speaker

♦ Don't
- take it personally or become defensive
- raise your voice to match the speaker
- interrupt or attempt to reason with the person while he/she is actively venting
- become argumentative or engage in a verbal power struggle
- touch the individual or enter his/her personal space

- If the person makes physical threats, becomes increasingly irate despite the counselor's efforts, or becomes physically intimidating, it is appropriate to conclude the interview for the time being and leave.
- Investigative activities/services, etc. will continue and contacts can be made at another time.
- No APS counselor should remain in a situation which puts him/her in danger.

In the event that there is an incident related to a threatening situation, an Employee Safety Incident Report must be filed. If the employee incurs an injury or health-related condition that requires medical care, she or he may be eligible for compensation. See **Section 1-15-01 Workman's Compensation** for procedures for filing claims for loss/damage to property or for medical care.

14-02 PRODUCTION AND USE OF METHAMPHETAMINE

The production and use of methamphetamine poses serious risks for our staff and clients. This section contains information about meth in the following areas:

- general information about methamphetamine
- recognizing the physical signs of a meth production site
- the risk to personal safety that the meth user may present
- hazards from the environment
  - ♦ to the APS staff
  - ♦ to the client
- protocol for APS with law enforcement.

If a referral is received in which there is reference to possible methamphetamine production or use, **DO NOT** go out on the referral without taking steps for your protection. **Immediately** contact your supervisor to plan for taking personal safety precautions (see **Section 14-02-04 Environmental Hazards** below) and involving law enforcement (see **Section 14-02-05 APS and Law Enforcement** below).

14-02-01 General Information About Methamphetamine

The production and use of methamphetamine (meth) is a significant problem in Tennessee. Although it has been most prevalent on the Cumberland Plateau, it is spreading to other parts of the state.

Meth is a synthetic stimulant that is produced in the form of pills, capsules, powder and crystal chunks. It is odorless. Pure meth is clear or white, although it can range in color from red to brown, depending on the chemicals used in its production and their contaminants. It can be ingested orally, absorbed as a suppository, smoked, snorted, or injected.

Meth is highly addictive. It works by artificially stimulating the reward or pleasure area of the user's brain without causing anything beneficial to happen to the body. As the pleasure center of the brain is intensely stimulated, the chemicals released in the brain become depleted over time, so that it becomes harder and harder for the addict to achieve the desired effect. Physical/behavioral effects of methamphetamine use include:

- Increased wakefulness and physical activity
- Increased sensitivity to sensory stimulation such as light and sound
- Decreased appetite at times leading to extreme anorexia
- Increased respiration
- *Hypothermia
- Euphoria
- Irritability
- Insomnia
- Confusion
- Tremors
- Paranoid delusional thinking
- *Convulsions
- Anxiety
- Paranoia
- Aggressiveness
- Violent behavior
- Hyperactivity
- Agitation

(Violent and aggressive actions are characteristic of individuals using methamphetamine.)

**Hypothermia and convulsions may result in death.*

Other possible visible physical effects

- Dilated pupils
- Increased pulse rate
- Injection sites if used intravenously

- Body tremors
- Rigid muscle tone
- Increased body temperature
- Teeth grinding
- Dry mouth
- Talkativeness
- Nasal redness and/or presence of small drug particles remaining in the nostrils if snorted
- Uncontrollable movements (twitching, jerking, etc.)
- Impaired speech
- Dry-itchy skin
- Acne
- Sores (may lead to severe infection)
- Numbness

Methamphetamine addicts and users have been known to experience a phenomenon known as "crank bugs," that are chronic hallucinations in which they perceive insects are crawling on or beneath the skin. Individuals experiencing 'crank bugs" will often scratch and gouge at their skin until it breaks open, subjecting the body to open sores and severe infection.

Cardiovascular side effects

- Chest pain and hypertension (may also result in cardiovascular collapse and death)
- Increased heart rate
-
- Elevated blood pressure (can cause irreversible damage to blood vessels in the brain, producing strokes).

Withdrawal effects

- Depression
- Irritability
- Mental confusion
- Aggressiveness
- Increased respiration and heartbeat
- Defective reasoning and poor judgment
- Weight loss
- Anxiety and tension

- Restlessness
- Increased body temperature
- Increased blood pressure
- Dryness of lips/mouth
- Decrease in energy
- Difficulty in sleeping
- Strong urge to use meth

Methamphetamine is a Schedule II drug under Federal regulations, meaning it has a high potential for abuse with severe liability to cause dependence. According to the Drug Enforcement Administration (DEA), methamphetamine has been the most prevalent, clandestinely produced controlled substance in the United States since 1979.

14-02-02 Manufacture of Methamphetamine in Clandestine Laboratories

Meth is produced from common chemicals which can be easily obtained from hardware, farm supply, grocery and drug stores. They are chemicals that are in common home and auto repair products, cold remedies and cosmetics. Meth is cooked in kitchens, garages, bathrooms, cars, or anywhere a stove or hot plate can be operated. Most, although not all, meth labs are located in secluded, rural areas to reduce the probability of detection.

Possible indicators that a meth lab may be present include:

- unusual strong odors like cat urine, ammonia, ether, acetone or other chemicals
- residences with windows blacked out
- trash piles with large amounts of empty containers from:
  - antifreeze
  - cough and cold remedies
  - nail polish remover
  - drain cleaner
  - peeled casings from lithium batteries
  - aerosol cans of starter fluid with puncture holes in the bottom, etc.
- unusual amounts of clear glass containers—jars, beakers, flasks
- propane tanks, plastic coolers, paint thinner
- plastic tubing or hoses, used coffee filters with other residue, (i.e. the appearance of a home laboratory)
- paper match books with no matches and the striker plate rubbed off

Any of the above separately would not be cause for concern. When found in combination and close proximity, the possibility of a meth lab should be considered, and the site treated as such.

Following is a list of the types of equipment, products and chemicals that are indicative of meth production.

Iodine

Lead Acetate

Lithium Aluminum Hydride
Magnesium

Mercuric Chloride
Palladium

Red Phosphorus Sodium

Sodium Cyanide

Thionyl chloride

Alcohol

Ether

Benzene

Toluene/Paint Thinner

Freon

Acetone

Chloroform

Camp Stove Fuel/Coleman Fuel

Starting Fluid

Anhydrous Ammonia

"Heat"

White Gasoline

Phenyl-2-Propane

Phenylacetone

Phenylpropanolamine

Iodine Crystals

Red Phosphorous

Black Iodine

Lye (Red Devil Lye)

Drano

Muriatic/Hydrochloric Acid

Battery Acid/Sulfuric Acid

Epsom Salts

Batteries/Lithium

Sodium Metal

Wooden Matches

Propane Cylinders

Hot Plates

Ephedrine (over-the-counter) Cold Tablets

Bronchodilators

Energy Boosters

Rock Salt

Diet Aids

Chemicals needed to manufacture meth are found in the following common household products:

Over-the-counter cough & cold medication

Fingernail polish remover

Red Devil Lye/Drano/Liquid Fire or other drain cleaner

Camera batteries

Table salt, rock salt

Denatured alcohol

Vehicle starter fluid or spray may be stolen from a farm and is often transported in a propane gas cylinder or a beer cooler

Road flares or match heads

Iodine crystals/Water binder obtained from farm supply store

Liquid Heet - from an auto supply store

Muriatic Acid

Hydrochloric Acid

Equipment that may be used in methamphetamine production includes:

Glass jars or mixing bowls

Propane tanks (as used for barbecue grills) to carry anhydrous ammonia

Plastic beer coolers to carry anhydrous ammonia

Large amount of coffer filters to strain liquids

Plastic tubing or hoses

A hot plate, camp stove or electric skillet for a heat source

A turkey baster to remove liquid from the top of a jar

In the majority of situations in which methamphetamine is being manufactured, it is also being used by those involved in its production.

14-02-03 Behaviors Associated With Methamphetamine Use

There is a high probability that if meth is being manufactured, that it is also being used.

Meth relieves fatigue, reduces the need for sleep, increases energy levels and in general brings about psychological and physical exhilaration. Users may go for long periods without sleep. As the drug high peaks and

declines, depression sets in. The user may become agitated, experience heightened sensitivity to sound, hallucinations, delusions, paranoia and sudden, unpredictable mood swings, going without warning from apparent passivity to potentially homicidal rage. This individual can be extremely dangerous, especially to anyone whom he/she perceives as a threat.

If the APS counselor finds her/himself in a situation in which there is someone suspected of using meth, the following precautions should be taken:

- Maintain a distance of at least 7 to 10 feet.
- Maintain a calm, low-pitched slow tone and pace in speech.
- Keep hands visible, avoid sudden movements
- Keep the suspected user talking. A meth user who falls silent may be extremely dangerous. Silence often means that his/her paranoid thought may have taken over, and anyone present can become part of the user's paranoid delusions.
- Do not sit down, and avoid any contact with surfaces in the area. See **Section 14-02-04 Environmental Hazards** below.
- Conclude the visit as quickly as possible and leave without arousing concern that drug use is suspected.
- Immediately wash your hands, shower and change clothes if possible. (See **Section 14-02-04 Environmental Hazards** below).
- Do not return to the site.
- Immediately inform your supervisor and law enforcement of concerns about the vulnerable adult in the home. (See **Section 14-02-05 APS and Law Enforcement** below).

14-02-04 Environmental Hazards in Methamphetamine Production

Because meth is manufactured through the use of caustic chemicals and volatile solvents, there is a high potential for:

- fire and explosion
- chemical contamination.

The lack of proper ventilation and temperature control in these homemade labs further compounds the problem. A variety of residues and solvents produced or used in the process get dumped into the ground or streams, contaminating the area and making it a hazardous waste site. Toxic vapors and gases are a by-product of the cooking process, including phosphene gas, which is a nerve gas. These gases do not totally dissipate into the air. They are deposited on and absorbed into porous surfaces, including walls, carpet, upholstery, linens etc., and are absorbed through the skin on contact with these surfaces. The degree of environmental contamination depends on how much and for how long the product has been manufactured on the site. The site will remain a hazard until it has

undergone professional hazardous material cleanup. Typical symptoms from exposure to these toxic substances include:

- skin rashes,
- unusual and persistent fatigue,
- unexplained and persistent muscle aches
- headaches
- respiratory problems.

1. Health and safety considerations for the counselor

   a. If the referral alleges the presence of meth production take the following precautions:

   - Plan with your supervisor to have protective gear (gloves, shoe coverings, paper gown, protective covers for car seats; see **Section 1-16 Ordering Special Supplies**).

   - Plan to have a complete change of clothes available.

   - Plan your investigative strategy with your supervisor to maximize safety from the environment or potential meth user.

   - Inform law enforcement as appropriate and coordinate activities. See **Section 14-02-05 APS and Law Enforcement** below.

   b. If the counselor finds him/herself in a situation which appears to be the site of meth production:

   - Do not sit down or touch any surfaces.

   - Observe and note (mentally) if possible specific chemicals which may be present so that observations can later be reported to medical and law enforcement personnel.

   - **DO NOT** use senses of smell or touch to attempt to identify chemicals or unknown substances.

   - Do not walk through any area where chemicals may have been spilled.

   - Conclude the visit as quickly as possible (see **Section 14-02-03 Behaviors Associated with Methamphetamine Use** above) without giving any indication of suspicions regarding meth production.

- If staff is exposed to the area or building where meth may be or has been manufactured, decontamination procedures should be observed as follows:

  - Change clothes, including shoes, as soon as possible; do not wear contaminated clothing, including shoes, into the home or office if at all possible.

  - Wash thoroughly with soap and water and shower as soon as possible.

  - Wash clothing in water and bleach mixture; after washing clothes, run an empty cycle through the washing machine with water and bleach mixture.

  - Carefully clean the soles of the shoes with water.

- Inform TBI, DEA or local law enforcement. See **Section 14-02-05 APS and Law Enforcement** below.

- If staff experience physical symptoms or suspect they have been exposed:

  - Seek medical attention immediately.

  - Inform the doctor of the possible exposure and of any specific observations of chemicals and/or odors that may help the doctor to determine whether the symptoms are related to exposure and how to treat the condition.

- Staff who believe they have been exposed to chemicals related to meth production should fill out a Safety Incident report which is available in the county office. The form is to be returned to DHS Personnel, 3rd floor, Citizens Plaza Bldg., 400 Deaderick St. Nashville, 37248-9700.

- Staff who believe they are experiencing health problems from exposure to meth production should file a Workman's Compensation claim. See **Section 1-15-01 Workman's Compensation** for procedure for filing a claim.

2. Health considerations for the APS client

   In general, the physiological systems affected by exposure to chemicals and toxic substances will be the same for everyone. Ill, disabled or elderly adults may be more sensitive because of existing health problems such as COPD, asthma, emphysema, high blood pressure,

confusion, slower activity of enzymes that metabolize medication and toxic compounds, etc. For these individuals, there may be increased concern about the effects on their red and white blood cell counts, kidney, liver and lung/respiratory function.

Following is a protocol suggested by the Department of Health for assessing and responding to medical needs of the client found at a methamphetamine lab site:

a. For an adult with obvious injury or distress, call 911 or other emergency number. Indications of medical emergency include skin rashes, respiratory or other distress. Be sure to advise any emergency medical personnel of the site's status as a meth lab and of the adult patient as having been exposed to chemicals.

   - If the adult's condition is potentially life-threatening, seek immediate treatment.

b. For the adult whose condition is not obviously critical, an initial medical assessment should be done no later than within 24 hours of discovering the adult at the meth lab site, or as soon as possible, by EMT, PHN emergency room or other, such as walk-in clinic, to determine whether there is need for immediate treatment. Prompt medical assessment is warranted due to the risk of toxicological, neurological, respiratory, dermatological or other adverse affects of meth lab chemical and/or stimulant exposure, and the high rate of neglect/abuse in these situations. Ill or elderly adults, whose health is already fragile, may more readily have adverse effects from chemical exposure. Health conditions that increase risk to these adults include chronic obstructive pulmonary disease (COPD), asthma, emphysema, high blood pressure; slow down of enzymes that metabolize medications and toxic compounds; confusion.

   - The initial assessment should include:
     - blood pressure—adults with high blood pressure could be adversely affected by meth, ephedrine or pseudo-ephedrine
     - pulse
     - respiration
     - temperature

   - Because APS staff are never expected to put themselves in danger, it is not expected or recommended that APS transport the client whose person may carry chemical contamination such as exposure to meth production. If, however, the counselor chooses to transport the client, at the very least, the following precautions need to be taken:

- the client's personal possessions should be left at the lab site/home, except for purse/wallet and coat;
- the client should wash skin areas with soap and water, if he/she is able,
- the counselor should use protective coverings that have been obtained from a clean environment (not from the contaminated site) such as plastic sheeting, bed sheets, bed spreads or table clothes, etc. on his/her car seat.

c. A baseline assessment at a medical facility is needed **within 24 hours** of the client's being found at the site due to the risk of toxicological, neurological, respiratory, dermatological or other adverse effects from chemical exposure. The counselor will need to ensure that the physician is informed of the client's history of chemical exposure and as much detailed information as is available about types of chemicals, symptoms, initial medical findings, etc.
   - Poison control should be called if clinically indicated.
   - Typical tests will include:
     - liver function tests: SGPT, SGOT, Total Bilirubin, and alkaline phosphatase
     - kidney function tests: BUN and Creatinine
     - baseline electrolytes: sodium, potassium, chloride and bicarbonate
     - CBC
     - Urine specimen
     - blood pressure
     - respiration rate
     - heart rate/pulse
     - other option clinical evaluations at the discretion of the physician
     - mental health screen

d. The client should have a visit for follow-up care **within 30 days** of the baseline assessment to reevaluate the adult's health status and identify any latent symptoms or need for further treatment.

Following is a chart of chemicals commonly used in the production of methamphetamine and the hazards which they pose:

Common Chemicals

Chemical	Description	Hazards
Acetic Anhydride	Clear liquid Vinegar odor	Vapors irritate eyes, nose and throat
Acetone	Clear liquid with sweet odor	Vapors irritate eyes and nose in high concentrations
Bromobenzine	Clear liquid, aromatic odor	Linked to leukemia
Chloroform	Clear liquid	Toxic to liver and kidneys Suspected carcinogen
Cyclohexane	Light yellow liquid with peppermint or acetone smell	Mucous membrane irritant
Benzaldahyde	Almond and cherry smell	Mild skin and respiratory irritant
Ephedrine	White crystalline substance	No major hazards
Ether	Clear liquid	**DO NOT OPEN CONTAINERS** Explosive
Glacial Acetic Acid	Clear liquid, solid at temperatures below 45 degrees Fahrenheit	Skin irritant
Hydriodic Acid	Clear liquid, may turn brown when exposed to air	**VERY DANGEROUS** Severe respiratory irritant
Hydrochloric Acid	Clear liquid	Will burn skin
Lead Acetate	White powder, heavy vinegar odor	Will absorb through skin and destroy nerve synapses
Mercuric Chloride	White powder	Deadly poison
Methylamine	Clear liquid, ammonia odor	Severe respiratory irritant, will burn skin on contact
Phenylacetic Acid	White crystals, urine odor	Skin irritant

Chemical	Description	Hazards
Phenyl 2 Propanone	Clear liquid, turns amber when exposed to air	Unknown, assume worst possible risk
Piperidine	Yellow liquid with soapy feel Strong ammonia odor	Strong central nervous system depressant
Sodium Cyanide	Chunky white crystal Bitter almond smell	Will form hydrogen cyanide gas if mixed with acid
Sodium Hydroxide	Powder, pellets, or white lumps, may also be a liquid	Corrosive to all tissues
Sodium Metal	Shiny silver	Ignites when exposed to water
Thionyl Chloride	Clear, yellow or red liquid with pungent, choking odor	Severely irritating to eyes, nose, and throat
Thorium Nitrate	White powder	Alpha radiation emiter

14-02-05 APS and Law Enforcement

Because the clandestine production of methamphetamine is a dangerous and illegal activity, the APS counselor who has a case involving a meth lab site will need to coordinate with law enforcement as well. The following procedure has been recommended by DEA and TBI.

- If the referral contains allegations of meth production, contact law enforcement before going out on the referral (see contacts below).

- If staff finds, without prior warning, that the home is a meth lab site, leave as promptly and unobtrusively as possible (see **Section 14-02-03 Behaviors Associated with Methamphetamine Use** above) and immediately notify law enforcement as described below.

- Following are guidelines for law enforcement notification:

  <u>NOTE:</u> If any law enforcement agency or individual asks APS staff to gain entry to a premises to acquire evidence and/or remove evidence so that law enforcement does not need to obtain a search warrant, <u>DO NOT</u> agree to this request:
  - **It could be hazardous for the counselor;**

  - **It would make any evidence obtained in this manner unusable by law enforcement for prosecution.**

- APS should notify local law enforcement (police department, sheriff's department, etc.) unless there is reason to directly notify the TBI or DEA. Most counselors will have a working relationship with a representative of local law enforcement and may have some experience with their capabilities.

- Local law enforcement in areas in which there is a volume of methamphetamine manufacture will have an established protocol for notifying and working with TBI and DEA. Ultimately, DEA is responsible for arranging hazardous materials (HazMat) cleanup of the site.

- If local law enforcement does not have a protocol for meth lab response, is not able to respond promptly to help the APS counselor or seems unsure of how to respond, APS staff can directly contact TBI or DEA.

The Tennessee Bureau of Investigation (TBI) will be able to coordinate their investigation with the Drug Enforcement Agency (DEA) as needed.

- TBI: Assistant Special Agent in Charge of Drug Investigations 615-744-4108;

  If not available,

- TBI: Assistant Director of the Drug Investigations Division 615-744-4250

- If the TBI cannot be accessed, staff can call the appropriate regional DEA branch:

Nashville	615-736-5988
Knoxville	865-584-9364
Chattanooga	423-855-6600
Memphis	901-544-3396
Johnson City	423-854-9100

or

- Vince Morgano, Special Agent, DEA 615-736-2917

14-03 CONTAGIOUS DISEASES

While anyone can be exposed to contagious diseases in the normal course of daily activity, there are three conditions which may be present in our client population which are of specific concern to staff. These are:

- AIDS (acquired immune deficiency syndrome)
- Hepatitis
- Tuberculosis (TB)

All of these infections are serious and can be life-threatening without proper diagnosis and treatment. All of the following information was obtained from the National Centers For Disease Control and Prevention (CDC)

AIDS and hepatitis are caused by viruses. Tuberculosis is caused by a bacterium. Of the three illnesses, AIDS tends to be the most feared because it is the newest to be recognized and effective treatment is not as well developed. However, it is not the most contagious nor the most commonly contracted. Following is information about:

- how each of these diseases is contracted
- steps to take to reduce the chance of contagion.
- steps if exposure is suspected.

Staff who believe that they have been exposed to any infectious disease while in the performance of job responsibilities will need to file an Employee Safety Incident Report. If staff believe they may be eligible for compensation for medical care, they may file for Workman's Compensation. See **Section 1-15-01** for the procedure for filing a claim.

See **Section 1-16** for information about ordering protective supplies.

14-03-01 AIDS

The human immunodeficiency virus (HIV) is the agent which causes acquired immunodeficiency syndrome (AIDS). The virus is transmitted through bodily fluids, primarily blood, semen, vaginal fluid and breast milk. The virus has been found in very low quantities in saliva and tears; it has <u>not</u> been recovered from the sweat of any HIV infected persons.

<u>Modes of Infection</u>

HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes with an infected person, through blood transfusion with blood not adequately screened. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding. Infection also occurs from accidental sticking with needles containing infected blood or contact between a source of infected blood and an open cut or mucous membranes such as the eyes or inside of the nose. All of the evidence **proves false** that HIV can be transmitted through air, water, insects or casual contact with surfaces or objects touched or handled by an infected person.

Precautions Against Infection

Staff who may be in contact with persons known or suspected to have HIV infection should observe the following precautions:

- Disposable gloves should be worn during contact with blood or other body fluids that could possibly contain visible blood, such as urine, feces or vomit.
- Gloves should be worn when staff may have contact with the infected person's open sores, cuts or other breaks in the skin.
- Gloves should be worn to cover breaks in the skin such as sores or cuts on the hands of staff.
- Cuts, sores or breaks in the skin on both staff and the infected person's skin should be covered with bandages.
- Hands and other parts of the body should be washed thoroughly immediately after contact with blood or other body fluids, and surfaces soiled with such fluids disinfected.
- Care should be taken to avoid handling or contact with needles or other sharp instruments which may be contaminated with blood or fluids from an infected person.

There is, as yet, no vaccine against AIDS, but there are a variety of treatment protocols to slow the progress of the disease, and a great deal of research is being done, with many new discoveries for treating HIV infection.

If an exposure occurs:

- Wash needle sticks and cuts thoroughly with soap and water.
- Flush splashes to the nose, mouth or skin with water.
- Irrigate eyes with clean water.

Follow up with procedures for filing an incident report and seeking medical care.

14-03-02 Hepatitis

Hepatitis is a viral infection that damages the liver. "Viral hepatitis" refers to several diseases caused by viruses that affect the liver. However the mode of infection by these viruses differs, as do the prevention measures and response to infection.

1. Hepatitis A

Modes of Infection

Hepatitis A is the disorder associated with unsanitary preparation of food or drink. Hepatitis A virus (HAV) is contracted by eating or drinking a

substance that has been contaminated by the virus, or by hand to mouth contact. It is passed through the gastrointestinal tract. Contamination with feces from an infected person is the typical avenue of infection. Household or sexual contact, day care attendance or employment and recent international travel are major risk factors. Infected food handlers and those who have used contaminated needles are also sources of contamination of food or drink. The infection can make you very ill for three to four weeks and usually resolves itself within 6 months. It does not develop into a chronic disease. It is very, very rarely fatal. Symptoms are fatigue, jaundice, fever and headache.

Precautions Against Infection

Hepatitis A is not likely to be a job risk to staff. The best prevention is to thoroughly wash:

- hands:
  - before handling food for preparation,
  - before handling anything that will go into the mouth.
  - after using the bathroom, changing diapers or handling anything that may have been contaminated with fecal material.
- surfaces and utensils used in food preparation

2. Hepatitis B and C

Although they are caused by different viruses, hepatitis B virus (HBV) and hepatitis C virus (HCV), these two forms of hepatitis are similar in that:

- they are both spread by exchange of body fluids or introduction of infected blood through transfusion, being stuck with or using instruments that are contaminated with blood from an infected person, etc.
- it is possible for the viruses to be transmitted at delivery from an infected mother to her baby.
- the diseases are chronic and can cause serious liver damage if untreated.

Hepatitis C is the most common blood-borne illness in the United States. A common avenue for infection is tattooing and body piercing with non-sterile instruments and conditions.

Precautions Against Infection

A significant difference between HBV and HCV is that there **is** a vaccine against HBV; at this time there is no vaccine available to prevent hepatitis C.

Other steps for prevention of infection from HBV or HCV are the same as with other blood-borne viruses such as HIV:

- Disposable gloves should be worn during contact with blood or other body fluids that could possibly contain visible blood, such as urine, feces or vomit.
- Gloves should be worn when staff may have contact with the infected person's open sores, cuts or other breaks in the skin.
- Gloves should be worn to cover breaks in the skin such as sores or cuts on the hands of staff.
- Cuts, sores or breaks in the skin on both staff and the infected person's skin should be covered with bandages.
- Hands and other parts of the body should be washed thoroughly immediately after contact with blood or other body fluids, and surfaces soiled with such fluids disinfected.
- Care should be taken to avoid handling or contact with needles or other sharp instruments which may be contaminated with blood or fluids from an infected person.

If an exposure occurs:

- Wash needle sticks and cuts thoroughly with soap and water.
- Flush splashes to the nose, mouth or skin with water.
- Irrigate eyes with clean water.

Follow up with procedures for filing an incident report and seeking medical care.

14-03-03 Tuberculosis

Tuberculosis (TB) is a disease caused by bacteria that usually attack the lungs. TB is spread through the air when an infected person sneezes or coughs. Exposure to the bacteria does not necessarily mean that a person will develop the disease or be infectious to others. In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria and stop them from growing. The bacteria become inactive, but they remain alive in the body and can become active later, particularly if the person later develops a condition that weakens the immune system.
People with inactive TB infection:

- have no symptoms, don't feel sick
- cannot spread TB to others
- usually have a positive skin test reaction
- can develop active TB disease at a later time if they do not receive preventive treatment.

Symptoms of active TB typically include:

- a bad cough that lasts longer than 2 weeks
- pain in the chest
- coughing up blood or sputum
- weakness or fatigue
- weight loss
- no appetite
- chills/fever
- night sweats

These symptoms can be associated with a number of conditions—the only way to determine whether you have tuberculosis infection is by diagnostic testing. This usually begins with a TB skin test. A positive skin test reaction does not necessarily mean that there is a current TB infection; however, it does indicate a need to discuss with the physician whether follow-up diagnostic tests are needed such as chest x-ray and/or sputum culture to determine whether there is need for treatment. The treatment protocol will involve taking antibiotics that are specific for TB bacteria, usually for at least 6 months. A person who is infectious will need to be in some sort of quarantine until treatment has rendered the disease non-infectious, which may take a few weeks. With TB, it is critical to continue taking all medications as prescribed to prevent resistant bacteria from surviving.

For procedures to file a claim for Workman's Compensation see **Section 1-15-01.**

SECTION 15- FAMILY HOMES FOR ADULTS

15-01 INTRODUCTION

The Department of Human Services is responsible for establishing policies and procedures for family home services for adults and approving homes accordingly. The policies prescribe the minimum standards to be met by the homes providing such care.

The Social Services staff was assigned responsibility for providing services to adults on July 1, 1971. During 1972, a survey was made that determined a critical need in the vast majority of counties for family boarding home care. As a way of meeting this need family home service was enacted November, 1974.

Each county office of the Department is authorized to approve and re-approve Family Homes for Adults that meet the minimum standards. Families and individuals wishing to provide family home care shall apply directly to the appropriate county office. Any home approved to provide family home care must meet minimum standards. In general, the services and facilities of the family home should be such that the person in family home care is not taken advantage of and his/her social and physical needs are met in a way that will protect and promote his/her health, safety, comfort and well-being.

Purpose

The purpose of Family Homes for Adults is to provide a family living arrangement for aged or disabled adults who do not require institutional or nursing care; whose own families are unable to care for them; and who are unable to take care of their own activities of daily living. Family homes may provide rehabilitative and preventive services for adults who can function in a family setting with minimal supervision but require help in maintaining themselves.

Legal Base

T.C.A. 71-1-105 authorized the Department of Human Services to provide family home care for adults who are unable to maintain an independent living arrangement. Enabling legislation for these homes was enacted during the 88th General Assembly (Public Chapter 337).

15-02 STUDY AND USE

15-02-01 Definitions

Family Homes for Adults are homes studied and approved by the Department as meeting minimum standards of care for no more than three elderly or disabled adults who can maintain themselves in a family setting with some supervision and help, but are unable to live alone or with relatives. The term "Family Home" is used to distinguish foster home care provided for adults from foster homes for children.

Sponsors are persons who are approved to provide family home care for adults.

Sponsor Family is used to designate the sponsors and the members of their immediate household.

Residents are recipients of Adult Protective Services who are residing in family homes for adults.

15-03 PERSONS SERVED IN FAMILY HOMES

- The persons selected for family home placement must meet the following criteria:
- Be a recipient of Adult Protective Services
- Have enough income to make the payment for board as outlined in **Section 15-17-08**, Instructions for Computing Board Payments and Payments for Services.
- Be ambulatory. This does not eliminate persons who may need some assistance in managing steps or getting around in unfamiliar places; or persons in a wheelchair who are able to get in and out of the wheelchair without assistance.
- Do not require nursing or institutional care.
- Be unable to live alone because of incapacities or infirmities which prohibit full self-care, e.g., health conditions preventing the assumption of full responsibility for housekeeping duties or forgetfulness which endangers self: but are able to care for personal needs such as bathing, dressing, etc., with minimal supervision.

- Be agreeable to placement, or placement may be made with a court order authorizing custody to provide protection from physical mistreatment necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life as stated in T.C.A. 71-6-107 (a)(5)(A).

- Be alert enough to plan for placement or will accept planning done for him/her by family, friends or others, or plans are made by a court appointed limited guardian or conservator.

- Be without a family with whom he/she can live, or with whom it is appropriate for him/her to live.

- Have a medical evaluation before a placement is made. This evaluation will be of assistance in determining whether family home care is appropriate from a health standpoint, whether the client's condition would be hazardous in any way to the sponsor family; and what medical regimen would be necessary.

The client's condition should be evaluated to determine whether any physical or mental condition would demand too much of the sponsor family or would mean that the client could not adjust to a family setting. In such cases, family home care should be ruled out. However, the ability of the client to be cared for in a family home setting rather than the nature of the handicap will be a decisive factor. If the client's physical, mental and emotional states are sufficient to enable him/her to fit into a family routine and the sponsor is willing to accept the client into the home, family home care may be considered.

15-04 THE FAMILY HOME STUDY

15-04-01 Purpose

The purpose of the family home study is to determine if the home meets basic standards of the Department and is suitable for care of a disabled or elderly adult client.

15-04-02 Application/Intake Interview

Person(s) indicating an interest in becoming a family home sponsor(s) shall be seen promptly for an application/intake interview. The initial interview shall include:

- exploration of their interest,
- general screening in regard to qualifications,

- explanation of the services,
- purpose for care in a Family Home for Adults,
- the role of the sponsor(s) in providing that care,
- the Department's responsibility to the resident(s) and family home sponsor(s), and
- general discussion of the home study process.

15-04-03 **Application to Provide a Family Home for Adults**

If after the initial discussion, the prospective sponsor(s) wants to proceed with the application, the *Application to Provide a Family Home for Adults, HS- 0070,* should be given to them for completion. Applicants must be advised that no further action will be taken until the application is returned. The application will be considered withdrawn unless it is returned within 30 days.

15-04-04 **Authorization for Release of Information**

The *(FA) Authorization for Release of Information, HS-2832,* must also be signed when the application is returned. The form will enable the counselor to make contacts and be given the information that is specifically required to complete the Family Home study.

15-04-05 **Financial Information for Adult Family Home Sponsor(s)**

Financial Information for Adult Family Home Sponsor(s), HS-1143, may be given with the application or completed during the interview with applicants.

15-04-06 **Medical Report - Adult Family Home**

The *Medical Report - Adult Family Home, HS-0066,* may be given at the time of the initial interview or the decision may be made to wait until the study has progressed to the point that the counselor anticipates approval. The advantage in waiting until the study has progressed is that those applicants who do not follow through or who will not be approved can be spared the expense of the medical examinations.

The applicant(s) must be advised of the need to secure a report on each household member from a physician or medical practitioner licensed to do screening evaluations, prior to approval. The report(s) must state that all members of the household are free of contagious diseases.

15-04-07 **Time Frame for Home Study**

The home study must be completed within six months from the application date and generally should be completed within a shorter time frame.

15-05 Registration

The registration date of the study will be the date the completed application is received in the county.

Family Homes for Adults cases are entered on the ACSS and are coded as case type **Q.** Case registration includes: a review of the *Application to Provide a Family Home for Adults, HS-0070,* for completeness (the application also serves as a face sheet); a check of the computer system to determine if the family or individual is already receiving service through our Department; assignment of a case number.

15-06 Method of Study

The family home study will be conducted via a series of interviews between the counselor and prospective sponsors and other members of the family group/household, as well as references having knowledge of the family.

15-06-01 **Interviews**

A minimum of three interviews is recommended. The interviews shall include the intake interview, interview(s) to initiate the study, and follow-up interview(s).

When a joint application is made, it is recommended that there be one separate interview with each. (The intake interview should be a joint interview).

At least two of the interviews must take place in the home of the applicant(s).

One additional interview should be held with other adults or children who live in the home.

a. Intake Interview

During the intake interview, the purpose of family home services should be explained to prospective sponsor(s) and there should be an exploration of the applicants' interest or motive for applying to

provide family home care. (Refer to **Section 15-04-02,** Application/ Intake Interview for additional information regarding the intake interview.)

The application is given to the prospective sponsor(s) during the intake interview. When applicants are husband and wife this should be a joint interview.

b. Interview(s) to Initiate the Study

This interview is initiated after the application is completed and returned. The counselor should explore the prospective sponsor's motivation and ability to provide family home care. There should be an exploration of their ability to meet the minimum requirements as sponsor(s) and exploration of the suitability of their home in meeting the minimum physical requirements.

c. Follow-up Interview(s)

Following the reference contacts and the return of financial and medical information, etc., an interview should be held to review information collected and re-examine prospective sponsor's motives, qualifications, and Department's expectations, policies and procedures. When a joint application is made, both prospective sponsors should be interviewed jointly.

15-06-02 **Verifications**

The following verifications are essential:

- Health of all members of the household
- Employment or other sources of income
- Inspections by environmentalist and fire inspector.

The *Fire Safety Checklist for Family Homes for Adults, HS-2431,* is to be completed by the counselor; or the local fire safety inspector, when one is available to inspect a home.

15-06-03 **CHARACTERISTICS AND REQUIREMENTS OF FAMILY HOME & SPONSOR FAMILY**

To qualify as a Family Home for Adults, the prospective sponsor(s), as well as their home, must meet certain standards, such as the following:

a. Home Atmosphere

The main phase of the home study deals with the household members of the prospective family home. The home atmosphere, organization of family life, and role distribution within the family setting, as well as the role and place to be assigned to the resident as a member of the home, should be evaluated. Children of the applicant(s) and others sharing the home must be included in the total evaluation of the home. It is important that the sponsor family not only be seen individually but also together. The division of responsibilities among family members, the flexibility of roles, the flexibility of performance, and how the individual members of the family relate to each other will give an indication of what can be expected of the sponsor family in terms of giving to and providing for a resident.

The warmth of the prospective sponsor family is frequently mentioned as a prerequisite. Although warmth is very important, it too needs assessment. How is the warmth exemplified in a life situation? Is it coupled with strength, endurance, tolerance for difference, for minor or sometimes even major interferences with established routine? Is this warmth radiating aimlessly or can it be directed and purposeful?

Although it is impossible to predict exactly how a home will function, at the conclusion of the home study a tentative opinion can be formed, based on the strengths and weaknesses observed during the family visits. Awareness of existing merits and shortcomings of the home becomes the guidelines in the matching process which precedes placement of the resident.

b. Number of Residents in a Family Home

No more than three (3) residents may be placed in a family home. It is anticipated that such arrangements will best serve one or two residents, since too many paying members of the household destroys the concept of family living.

c. Family Composition

There are no specific requirements about the size of the family that is to provide family home services for adults. Some clients may be pleased that children in the household offer them the opportunity to play the role of substitute grandparent, while others would feel that

the quietness and calmness of a childless home would be very appealing. For many adults needing family home services, a one-person family would be acceptable. The greatest percentage of family home services is offered by widows.

If the family includes one or more persons who need considerable care and attention (small children or an incapacitated adult) the situation should be evaluated carefully to determine whether the needs of all members of the household can be met adequately while family home care is provided for one or more persons.

d. Age of Sponsor(s)

Sponsors must be adults (at least age 21). The upper age limit of sponsors will depend upon health and capability to provide necessary care. Age verification is required only if there is reason to question that the applicants are below the required age.

e. Health of Sponsor(s)

Information must be obtained regarding the health of all members of the household who will interact with the adult. Reports must be secured as indicated below:

1. Prior to approval, it must be established that the sponsors and other members of the household are free of contagious diseases; the sponsors are in good enough health to provide care for one or more residents; and that their health condition would not be detrimental to the type of resident to be served.

   Reports will be acceptable from a licensed physician or medical practitioner. The information may be obtained in one of the following ways:

   a. A report based on current treatment as indicated above.

   b. A report based on an examination done within one year prior to the date of the application.

   c. Completion of the Medical Report - Adult Family Home, HS-0066.

2. For each member of a household under current medical treatment an Authorization for Release of Information,HS-2832, shall be secured from the adult applicant or parent of the child being treated. This release is to be sent to the treating physician with a request for a report of the person's condition, specifically as it relates to the placement of an adult in the home.

   When a sponsor has an ongoing medical condition that would not currently prevent him/her from providing care the physician will be requested to state at what point an updated medical report is needed.

3. A report or statement that other members of the household are free of contagious diseases must be secured, prior to approval.

4. Interim reports are required when any member of the household appears to have a condition (physical, mental and/or emotional) indicative of being a hazard to a resident, or at the time of a re-evaluation as indicated above. Failure to provide such a report within 60 days of request will result in closure of the family home. If an immediate risk appears to exist for the resident, then a report may be required in less than 60 days.

5. Local offices have the option to obtain annual reports if they feel it is indicated.

f. References

The sponsor family must be qualified to provide family home care by virtue of training or experience. All members of the sponsor household must be responsible people of good character and reputation (as verified by references), and all must be willing to accept the resident into the home as a member of the family.

The sponsor family will be requested to provide the names, addresses, and telephone numbers of at least three (3) persons to serve as references. The references should be able to attest to the applicant's emotional and physical fitness to provide a home atmosphere conducive to the well-being of a disabled adult or elderly person. At least two of the references should be unrelated. However, contacts with relatives are encouraged when feasible.

When negative reference reports are received the concerns must be discussed with the sponsor, although the source or reporter of the negative concerns will not be identified. This should be explained to the sponsor applicant when the reference contacts are obtained.

The reference contacts may be by phone, or letter, unless there is indication of the need for a more personal contact. The counselor may contact additional references that have not been provided by the sponsor family, when indicated.

g. Income

During the study process, it should be determined that the family has a stable income sufficient to maintain their own family without the supplementation of a board payment. The Financial Information for Family Home Sponsor(s), HS-1143, is to be used to secure this information. Families with limited income may be considered for approval when evidence indicates that they are able to manage within the limits of their income.

If at any time, following approval, a major change affects the sponsor family's financial stability and the family home boarding payment is known to be or suspected of being used to fully meet the needs of the sponsor family the Financial Information for Family Home Sponsor(s), HS-1143, must be completed. Information on the form must be verified and, if the suspicion is confirmed, it will be grounds for closure if the financial situation is likely to exist for an indefinite period.

h. Supervision of Residents and Employment Restrictions

A responsible adult sponsor must be available in the home to provide necessary supervision for the resident(s), except for relief help or brief absences approved by the Department.

It is possible however, for a sponsor to be out of the home for periods of time during the day, i.e., run errands or part-time job, depending upon the resident's need for care and supervision. For instance, when the resident is outside the home for part of the day, the sponsor could be employed outside the home for the same hours or less if it is determined that such employment would not have a detrimental effect upon the provision of family home care.

The Department must be notified and concur with the sponsor(s) absences/employment and their plans for the resident(s) during the absences/employment.

i. Transportation

Sponsor(s) must be able to provide or arrange for transportation as necessary for routine medical care and for the resident(s).

Department staff may provide necessary transportation which exceeds the routine transportation provided by sponsor(s). Transportation by Department staff or reimbursement to the sponsor family should only be provided under exceptional circumstances. Refer to **Section, 15-17-05**, Reimbursement for Special Transportation for further discussion on reimbursement to sponsor families for transportation.

j. Religion

The sponsor family should respect the resident's preference for worship and arrange or provide transportation for the resident to attend such services when necessary.

k. Attitude of Sponsor toward Department

- Sponsors should be able to accept supervision from the Department, including home and office interviews. In order to work successfully with the Department the sponsor will need to be able to:

- Share with the Department difficulties encountered with the resident, his family, or the sponsor's own family because of the resident's presence.

- Notify the Department about illnesses as well as serious manifestations of disturbing behavior.

- Abide by medical regimen prescribed for the resident.

- Assume partnership with the Department in helping the resident toward a more meaningful and satisfactory life.

l. Location of Family Home

Family homes should be easily accessible to services, social contacts, medical care, etc., to meet the needs of residents placed in the home. A primary concern is to provide for the resident the kind of living arrangement that will be conducive to activity outside, as well as inside, the home.

15-06-04 FAMILY HOME SAFETY: SAFETY FEATURES AND EQUIPMENT

a. Fire Safety and Building Safety Ordinances

Family homes must conform to the local ordinances pertaining to fire and building regulations.

- **Fire Safety Checklist for Family Homes for Adults, HS-2431**

  This checklist should be completed by the counselor or local Fire Safety Inspector at the time of the original home study and at the time of each annual re-evaluation.

- **Exterior Conditions**

  The family homes and grounds shall be free from anything which constitutes a danger such as: abandoned automobiles and household appliances or articles, uncovered wells or cisterns, stagnant water, stacked lumber with exposed nails, highly flammable liquids and explosives.

  All of the windows and doors must open freely and meet requirements regarding size, location etc., as specified on the *Fire Safety Checklist for Family Homes for Adults, HS-2431*.

  They must also be screened against insects (unless the home is air conditioned).

b. Interior Conditions

The home shall be maintained in clean and orderly conditions for the health, well-being and safety of residents. All required safety equipment shall be maintained in good repair and in safe operating condition.

The exits and hallways shall have night lighting and be kept clear of equipment, furniture or other obstacles at all times. All exits must be readily accessible.

There should be good lighting throughout the house.

Stairways and steps must have banisters or hand railings. There should be safety bars in the bathroom(s).

Safeguards must be provided against potential hazards such as: guns, poisons, drugs/medication, open fires, unprotected heaters, floor furnaces or slippery area rugs.

c. Exit Ramps

A family home which provides care for a resident who uses a wheelchair must have exit ramps. The ramp must meet specifications as stated on the *Fire Safety Checklist for Family Homes for Adults, HS-2431*. The family home which accepts adults who use a wheelchair must meet the following criteria: have interior doors that are at least 32 inches wide and have a ramp with no more than a 1 inch fall (1 inch drop to 12 inches out).

d. Fireplaces

A family home that has a fireplace must have a protective screen that is secured in place. When the fireplace is used as a primary source of heat it must be inspected annually. If the fireplace is used only occasionally it must be inspected at least biennially or as indicated by the inspector. See *Fire Safety Checklist for Family Homes for Adults, HS-2431,* for more information regarding fireplaces.

e. Smoke Detectors

Electrically operated smoke detectors with battery back-up are recommended but UL approved battery powered smoke detectors are acceptable. Battery operated smoke detectors must be tested and maintained in operable conditions at all times. Smoke detectors shall be installed in each bedroom occupied by a resident, corridor(s), kitchen, and any hazardous area.
Note: Newly constructed homes must have hard-wired smoke detectors with battery back-up.

f. Fire Extinguishers

The home must have on each floor/level an approved A-B-C Fire Extinguisher with needles and gauges. The extinguisher must be readily accessible and fully charged at all times. It should be near an escape route, but away from potential hazards such as directly over a range.

A pressurized fire extinguisher must be properly serviced and maintained at all times.

A disposable extinguisher can be used only once. Then it must be discarded and replaced.

15-06-05 Housing Arrangements and Furnishings

a. Bedrooms and Furnishings

A private room for each resident is desirable but not required. The resident should not share a room with a member of the sponsor family but can share a room with another resident if both agree to that arrangement and a minimum of 72 square feet of bedroom space is available for each resident. A minimum of 80 square feet is required if a resident occupies a separate room.

A comfortable bed, sufficient drawer and closet space for clothing and a reasonable amount of space for other possessions (keepsakes, etc.), a comfortable chair, table or desk and adequate lighting, heat and ventilation must be provided for each client. The furnishings must provide for safety and comfort.

For some residents, a room on the ground floor with a bathroom would be essential.

The resident must have free access to common living areas of the home, just as the sponsor family.

b. Upstairs Bedrooms

Upstairs bedrooms may be used only for residents who are physically able to manage stairs. In those instances the upstairs bedroom must have an access to an outside exit from that level, as specified on the *Fire Safety Checklist for Family Homes for Adults, HS-2431*.

c. Bathrooms

The bathrooms must be conveniently located to the resident's bedroom and must not be shared by more than six persons. Family homes with more than six occupants must have at least 1 1/2 baths. Non-skid strips (or mats) and safety rails or grab bars must be provided for safety in the bathtub or shower.

When the family home is serviced by a septic tank it must be operating correctly.

d. Telephone

There must be a telephone in the home and the resident must be allowed reasonable use of it for local calls.

15-06-06 **Meals**

Sponsors will provide a minimum of three meals per day which are well-balanced, wholesome, varied and reasonably spaced.

These meals will adhere to medically prescribed diets and be served in the family setting except during brief periods of illness when the resident needs to have meals served in his/her room.

The amount and kind of food, the timing of meals, where and how they are served, and how free the resident can feel to ask for an additional helping or a supplementary snack, should all be considered.

Some attention to personal food preferences will in many cases help the resident to feel like a member of the family and facilitate the adjustment process. The sponsor's readiness to provide special diets because of chronic or acute illness should be ascertained. Special diets generally involve extra expense and may also require more frequent servings.

15-06-07 **Water Supply**

There must be a safe water supply. Proof of a safe water supply is required when water is obtained from a private source, such as a well on the sponsor's property.

15-06-08 **Mobile/Modular Homes**

At the onset of the Family Home program, sponsors who lived in mobile/modular homes were not approved to provide family home care.

Because of the improvements and changes in mobile/modular homes we are now, under certain conditions, able to approve family home sponsors who reside in them. The mobile/modular home must meet the following conditions to be approved:

- Be 24 feet wide/double wide;
- Have front and rear exits;
- Be anchored/tied down with wheels removed;
- Built in 1974 or after 1974

15-07 RECORDING FORMAT FOR THE FAMILY HOME STUDY AND ANNUAL RE-EVALUATION

15-07-01 Outline For Family Home Study

The information included in this section: The study and the annual re-evaluation must incorporate the information included in the entire **Section 15-04**, The Family Home Study. This information will assist the counselor in making accurate decisions regarding the appropriateness of the home, as well as appropriate placement decisions.

The study should include the strengths and weaknesses of the sponsor family as well as provide a complete picture of the home setting. To ensure that this is done, particular attention is focused on **Section 15-06-03**, Characteristics and Requirements of the Family Home and Sponsor Family.

The following outline is suggested as the recording format for the Family Home Study:

a. Referral and Identifying Information

Include information such as the following:

- Date of inquiry
- Date of application
- Name of counselor
- Full name(s), address(s), and telephone number(s) of the applicant(s)
- Brief statement of applicant's statement of interest/motivation
- Plans for follow-up

b. Summary of Interviews with Applicants

Include information such as the following:

- Dates of interviews and summary of information shared and discussed. This may be a simple statement referring to

general material covered or may be specific to the extent that is believed by counselor and supervisor to be necessary.

- Areas of particular interest/disinterest and agreement/ disagreement observed by the counselor.

- Identification of particular strengths displayed in interviews.

- Identification of areas of concern indicating need for further clarification.

c. Evaluation of Characteristics and Requirements of Family Home and Sponsor Family

Refer to **Section 15-06-03**, Characteristics and Requirements of Family Home and Sponsor Family. The items listed below are discussed in detail in that section:

- Home Atmosphere
- Number of Residents in the Family Home
- Family Composition
- Age of Sponsor(s)
- Health of Sponsor(s)
- Income
- Plans for Supervision of Resident(s)
- Plans for Transportation
- Plans for Resident(s) Participation in Worship Services
- Attitude of Sponsor(s) toward Department
- Location of Family Home
- Exterior Conditions
- Interior Conditions
- Smoke Detectors
- Fire Extinguishers
- Bedrooms and Furnishings
- Bathroom(s)
- Telephone
- Water Supply

When appropriate the following will also be included and addressed under this section:

- Exit Ramps; Fireplaces; Upstairs Bedrooms; and Mobile/ Modular Homes.

d. Evaluation of Required Forms/Reports

- Fire Safety Checklist, HS-2431
- Building Safety Reports
- Application, HS-0070
- Financial Information, HS-1143
- Medical Report, HS-0066

e. Evaluation of Reference Contacts

- Identification of references, including name; address; telephone number(s); relationship to applicant (friend of many years, new neighbor, member of same church, etc.)
- Date(s) and method(s) of Reference Contacts (telephone, home visit, letter, etc.) of contacts
- Summary of information gathered

f. Counselor's Recommendation

This section states whether or not the **home** and **sponsor family** meet minimum requirements to provide Family Home care. Include the number and type of persons(s) for which the home and family are approved to provide care.

g. Disposition of Application

The counselor and supervisor must sign and date the study, either approving or rejecting it.

15-07-02 **Outline For an Annual Re-Evaluation**

a. Significant changes in home situation:
See Evaluation of Characteristics and Requirements of Family Home and Sponsor Family **(Section 15-06-03)**. As appropriate include information such as the following:

- family composition
- income
- health of sponsors/sponsor family
- housekeeping standards, etc.

b. Problems encountered
Include problems dealt with successfully or those that have not been dealt with successfully

c. Sponsors' relationship with resident:

- changes and/or improvements
- ability to stimulate and encourage residents
- physical care of resident(s)
- utilization of community resources
- attitude toward residents

d. Attitude toward accepting residents in the future:

- ability to provide care for adults with different types of needs

e. Discussion of any complaints received (give details and impressions).

f. Cooperation with Department.

g. Evaluation of required forms/reports (see **Section 15-07,** Family Home Study).

h. Counselor's recommendation.
In this section state whether or not the home and sponsor family continue to meet minimum requirements to provide Family Home care. Include the number and type of person(s) the home and family are approved to provide care for.

The counselor and supervisor must sign and date the study, either continuing the home or closing it.

15-08 LICENSURE

Family homes recruited and approved by the Department do not require licensure by the Department of Health and Environment. They also, do not require licensure by the Department of Mental Health and Mental Retardation. Department family homes are approved for the placement of Adult Protective Service clients only and are not open to the public in general; therefore a license is not required.

Should a person already licensed by the Department of Health and Environment wish to apply to become a sponsor of a family for adults, the Department of Health and Environment license may be accepted in lieu of the fire and health inspections as these inspections will have already been completed prior to issuance of the license.

15-09 LIMITED USE OF FAMILY HOMES

Family home sponsors may not provide care under the supervision or auspices of another agency nor accept children or adults either for pay or on a free basis without Department approval. Approvals on a short-term basis may be considered for unrelated persons, whereas approvals may be considered on a permanent basis for relatives as long as other standards are met.

A home operated as a boarding home, rooming house or day care facility will not be approved to provide family home care for adults.

15-09-01 Special Situations for Providing Adult Family Home Services

A Family home for adult care may be considered for a foster child who has reached adulthood and is no longer in child foster care, but is unable to achieve independent living. The following criteria must be met:

a. The adult must meet the criteria as stated in **Section 15-03**, Persons Served in Family Homes.

b. The former foster parent must agree to no longer provide care to any additional foster children or adults under the supervision or auspices of another agency. **(See 15-09)**

c. The former foster parent must understand and agree to the Department's payment plan for board and other services for adults in family homes when they change from providing foster care to children to providing family home services to adults (Refer to **Section 15-17**, Payment for Family Home Care, for more information).

d. Utilizing these homes for the care of a former foster child is subject to the availability of funding.

e. An environmentalist report and fire safety report must be completed on a foster care home before it is approved to provide family home for adult care. Also the home study for adult family home services should be completed.

All former foster families providing family home care for the first time should be helped by the counselor to understand the new payment procedures, and the differences in the Department's responsibilities for the resident, versus the foster child. For instance, a child in foster

care may receive an initial clothing allowance. Monthly allowances for personal incidentals and clothing are included in the board payment for the adult. Medical and psychological expenses are covered by the adult's own resources.

In an adult foster home the sponsor is not the legal decision-maker for the resident unless they have been court appointed.

15-10 APPROVALS

The home should be approved, generally, if applicants are:

- accepting of Department policies and procedures;
- do not have negative reference reports;
- meet the criteria stated in **Section 15-06-03**, Characteristics and Requirements of Family Homes and the Sponsor Families.

Sponsors should receive written notification of the approval.

The sponsor will provide specific information regarding the number and type of resident(s). This information should be in the case file.

15-11 REJECTIONS/CLOSURES OF APPROVED HOME

The following criteria are usually indicators of unacceptable conditions and may serve as the basis for rejecting an application or closure of an approved family home. Exceptions are recognized and judgment is required in evaluation of these criteria:

a. The applicant/sponsor requests that the application be terminated or the home be closed.

b. Insufficient Income

The family does not have sufficient income to meet its financial obligations. Evaluate the information submitted to determine if family expenses exceed income. If verification of information of the financial form indicates that board payments are required to meet the family's expenses, the home may not be used.

c. Evidence of an unstable life style as demonstrated by:

- Multiple marriages that are frequent and short-termed.
- Frequent periods of unemployment and/or job changes without good cause.

- Frequent moves without reasonable explanation for such moves.
- A history of criminal activities.
- A history of alcohol/drug abuse.
- Evidence of an unstable marital relationship as demonstrated by frequent separations.
- Evidence of severe emotional disturbance documented by a professional evaluation or medical records.

d. At least two (2) of the three (3) negative references express similar concerns.

e. Insufficient space in the home or home not meeting minimum health and safety standards.

f. Housekeeping standards that may be threatening to the health of an adult; such as, improper care of food, or evidence of rodents.

g. Health problems that preclude the individual's ability to provide appropriate care for an adult.

h. Evidence of involvement in illegal activities.

i. Suspected or confirmed inability to work cooperatively with the Department.

j. Expectations for adult residents are unrealistic.

k. Failure to complete forms within time frames specified.

l. Lack of friends or relatives to assist family in emergencies.

m. Unwillingness or failure to comply with Title VI of the Civil Rights Act of 1964.

The decision to reject or close a home must be thoroughly discussed with the applicant and/or sponsors and confirmed in writing. This is not an issue that can be appealed, since family home sponsors are not recipients of a service from the Department. They do, however, have the right to a supervisory review of the rejection or closure.

15-12 CONTACTS FOLLOWING APPROVAL

a. At least quarterly contacts must be made with approved Family Home sponsors from the time of approval, until a placement is made. These visits are necessary to keep the sponsors aware of the Department's plans regarding the home and to keep up with any changes in the family home.

b. During pre-placement planning, contacts will be made which are necessary to assist sponsors in making a decision about accepting the prospective resident.

c. Following placement, regular supervisory visits will be made. See **Section 15-18**, Procedures for Placement and Supervision for more complete information on the supervision and placement of residents.

Experience in foster care programs for children and adults has shown that some homes are lost before they can be used. It takes time to find the right combination of home and client. Reassurance from the counselor that they have not been forgotten is in order. Also, group meetings of those providing family home care and those applying to do so have been found helpful in maintaining interest until at least one client enters the home. Such meetings, while mainly educational in nature, also serve another function. They offer the group the opportunity to discuss mutual questions and problems and to develop a feeling of group identity and belonging. Realization of the importance of the job they are doing and its value to the community brings a sense of pride and status which are rewards themselves and sustain sponsors in their continuing efforts.

15-13 RE-EVALUATIONS

If at any time during the year the counselor determines the necessity for re-evaluation of a family home, a re-evaluation will be initiated.

An annual re-evaluation of the home is required to assess with the sponsor the care which has been provided, improvements which may need to be made, changes in the kinds of residents they may best serve, and other changes which affect the capacities to provide care for adults. Information may be gathered from other sources to document the counselors' findings. The reevaluation should include the following:

- A determination that the family does or does not continue to meet the minimum requirements for sponsor families and residents.
- An evaluation of the Department and sponsor family's relationship.
- An assessment of the families' ability to meet the needs of resident(s) who are placed with them.
- Areas of particular strength.
- Areas where improvement is needed.
- Other changes in the home that would affect the sponsor's capacity to provide care.
- County offices have the option of requesting annual medical reports if they feel such reports are justified.
- A recommendation regarding changes needed, continued use of the home, or closure.

The recording format for the annual re-evaluation of the family is included in **Sections 15-07-01**, Recording Format for The Family Home Study and **15-07-02,** Annual Re-Evaluation

15-14 CLOSURE OF APPROVED HOME

The criteria stated in **Section 15-11,** Rejections, are applicable to the closure of an approved family home.

15-15 RESPONSIBILITIES OF THE DEPARTMENT

The responsibilities of the Department are as follows:

1. Recruit, study, and approve family homes in accordance with standards established for care.

2. Provide to the sponsor family adequate information concerning each adult considered for placement and assist the sponsor and the potential resident in making the decision about placement.

3. Supervise the care given to the resident in the placement. Staff must be available for consultation with both sponsor(s) and resident(s). Visits must be arranged in the home whenever indicated to examine and/or to investigate concerns or problems and offer guidance. At least monthly visits should be made. However, once the placement has stabilized, quarterly visits may be considered. The decision regarding quarterly visits should be made in consultation with the supervisor.

4. Assist sponsor(s) in locating and participating in training which will be beneficial in alleviating, reducing or coping with the problems affecting residents.

5. Give the sponsor(s) specific information on how to contact a Department representative at all times.

6. Develop a plan for emergency situations which may necessitate immediate removal of a resident; or provide assistance to the sponsor(s) to enable them to maintain the family home during emergencies.

7. Assist sponsor(s) in making suitable plans for the resident(s), such as recreational activities, family visits, etc.

8. Involve the resident's family in planning; including emergency temporary replacements, medical care, future living arrangements, etc.

9. Assist in seeking appropriate medical care. The resident will need to use TennCare/Medicare or other available resources. APS does not have funds to pay for the residents' medical care.

   Consent by DHS for evaluation or treatment of a resident will require a referral to the Department's legal staff. (See **Sections 6-02**, Provision of Protective Services Without the Consent of the Adult and **6-04**, Court Ordered Mental or Physical Examinations-Only).

10. Provide information to the sponsor(s) about resident's legal representative or conservator who can give consent to medical care and act on behalf of the resident in situations when the resident is unable to do on his/her own.

11. Arrange or provide reimbursement for exceptional transportation that may be required for special medical needs of the resident.

12. Discuss, complete, and submit to Fiscal Services, the *Adult Placement Contract, HS-0071*.

13. Make a payment each month for services to the sponsor(s) as shown on contract for the duration of the contract as applicable.

15-16 RESPONSIBILITIES OF THE FAMILY HOME SPONSOR

The responsibilities of the Family Home sponsor are as follows:

1. Abide by regulations and standards for family home care as stated in this section.

2. Provide the recommended daily care of the residents accepted and placed in the home.

3. Provide care to resident(s) of all races and/or national origin.

4. Accept the resident(s) as a member of the family and give him/her access to the common living areas of the home.

5. Provide assistance or supervision as recommended by the resident's physician.

6. Provide or arrange for transportation as necessary for routine medical care and for the residents' participation in community activities.

7. Provide family home care only for adults whose placement is arranged through the Department.

8. Be available in the home when the resident is present except when relief help or short absences are agreed upon with the Department.

9. Develop appropriate procedures to account for those personal items and funds entrusted to the sponsor(s) by the resident(s).

10. Observe and share information about the well-being of the resident with the Department.

11. Notify the Department and the designated relative/friend of any emergency situations related to the resident and report any unusual sickness, accident or disturbing behavior.

12. Allow the representative of the Department to visit the home at any reasonable time (usually by appointment).

13. Provide the opportunity for the counselor to interview the resident in private, upon request.

Accept supervision by the Department and cooperate with the counselor by following suggestions and recommendations regarding the health and well being of the resident.

15. Give each resident the opportunity to attend the worship service of his/her choice if he/she wishes to do so.

16. Accept the counselor's decision to remove a resident when, in the counselor's opinion, such removal is necessary.

17. Maintain good physical standards in the home, giving consideration to the safety, light, heat, ventilation, cleanliness and sanitation, and comply with regulations concerning these matters.

18. If the sponsor(s) wishes to terminate the placement, the Department should be given thirty (30) days, if possible, to assist the resident in making new plans.

19. Report to the Department any change of address.

20. Report to the Department any serious or continued illness in the family household.

21. Read and sign the *Adult Placement Contract, HS-0071*

22. Sign the *Sponsor Invoice, HS-2858* each month.

15-17 RESPONSIBILITIES OF THE RESIDENT

1. Participate in planning for the placement to the extent possible.

2. Consent to the placement.

3. Participate in family activities to the extent possible.

4. Use facilities of the home as other members of the family with due regard to their needs as well as his/her own.

5. Observe reasonable rules of the home, and the rights of others in the home, i.e., hygiene and personal care.

6. Accept the assistance and supervision of the sponsor(s) as recommended by the physician.

7. Consult regularly with the Department representative and notify the Department of matters that affect continuation of the placement.

8. Pay room and board each month and all or a portion of the payment for services depending on income, (when the resident's income do not exceed the usual SSI payment, payment for service will be made by the Department).

9. Read and sign the *Adult Placement Contract, HS-0071.*

15-18 PAYMENT FOR FAMILY HOME CARE

15-18-01 General Provision

Residents in family homes are required to pay the board payment as determined by the Department. The Department may provide a portion of the service fee or the full service fee paid to sponsors. If a conservator has been appointed, this person will assume responsibility for management of the resident's funds. See **Section 15-17-08**, Instructions for Computing Board Payments and Payments for Services for specific directions**.**

15-18-02 Board Payments

Board rates are established in conformity with the SSI standard payment. The resident must pay the cost of room and board from his/her income. The amount paid by the resident shall be for a furnished room, meals, utilities, laundry, and other miscellaneous services incidental to room and board which are provided by the sponsors. The resident retains for his/her own use an amount for clothing and personal incidentals. See **Section 15-18-08**, Instructions for Computing Board Payments and Payments for Services for specific directions.

15-18-03 PAYMENT FOR SERVICES

A payment for services is made to sponsor(s) in addition to the room and board payment. For the resident whose income does not exceed the SSI amount, payment for services up to a maximum of $220 will be made by the Department. However, when the resident has income in excess of the SSI standard payment, the excess shall be paid to the sponsors for services, up to a maximum of $220 per month.

Such services shall include but are not restricted to:

1. Sponsors are required to provide routine transportation that is necessary for the resident's physical and social well-being, including doctor's visits. If they are unable to provide the transportation they are expected to arrange for routine transportation.

2. Assisting residents in their introduction to the community and its resources and follow-up in their participation in various activities;

3. Assisting residents in maintaining relationships with meaningful relatives and friends;

4. Participating in training opportunities which may assist sponsor(s) in improving the care and services provided to resident(s).

5. Providing needed supervision to resident(s).

15-18-04 Emergency Board and Service Payments

APS can authorize for up to three months emergency board payments for Adult Foster Care clients whose income has been used or exploited, have no other source of income until their next pay check, or until they get approved for SSI, Social Security, etc. The service fee and the emergency board payment for the partial month are calculated by determining the daily rate and then multiplying that rate by the number of days used that month. **NOTE:** When prorating, check if the month being documented had 28, 29, 30, or 31 days. The amount due for each item is entered in the sub-total column on the Sponsor Invoice when submitting to DHS Fiscal Services Unit. See **Section 15-18-06**, Forms to be Submitted to Fiscal Services, for instructions.

15-18-05 Reimbursement for Special Transportation

It is expected that sponsors will provide routine transportation. However, under exceptional circumstances reimbursement may be considered for transportation for special medical or other special needs. The counselor and supervisor will approve requests for reimbursement for such transportation. The following factors will need to be considered:

- Frequency of travel for medical services i.e., daily versus weekly;

- Distance of travel to the service resource. The exceptional travel may involve examinations/treatment available only in a distant city as opposed to travel within a reasonable distance to medical resources which are routinely relied upon in the sponsor's community or town.

- The sponsors may be reimbursed only when a diligent effort has been made to locate transportation and the only alternative is for the counselor to provide it.

All requests for reimbursements must be carefully considered. The case file must document the need for reimbursement with a travel claim form

provided by the sponsor. The approved reimbursement is documented by APS staff on the APS-Adult Foster Care Sponsor Invoice, noting destination, state mileage rate, total miles per trip, and reimbursement amount. The Sponsor Invoice is mailed to DHS Fiscal Services Unit and a copy is retained in the case file.

15-18-06 **Forms To Be Submitted To Fiscal Services**

An *Adult Placement Contract, HS-0071*, must be completed for each adult in care. When an adult is placed in a family home and **DHS pays** part or all of the fee for services:

- **send the original,** *Adult Placement Contract, HS-0071,* to the State Office **Fiscal Services** Unit as soon as possible,
- place a **copy** of the contract in the DHS case file,
- give a **copy** to the sponsor(s), also
- give a **copy** to the resident.

When the placement contract is for an **adult paying** the **full fee** for services:

- place the **original** contract in the DHS case file,
- give a **copy** to the sponsor(s), also
- give a **copy** to the resident.

The Authorization to Vendor Form and the APS-Adult Foster Care Sponsor Invoice Form certifies that services were completed and payment(s) is required. Both documents should be submitted to the State Office, Fiscal Services Unit as follows:

- submit the original documents with original signatures (no faxes; keep copies for your records),
- submit the Authorization to Vendor form each time the contract payment amount changes, and
- submit the Sponsor Invoice form each month.

The mailing address is:
Tennessee Department of Human Services
Fiscal Services Unit-**5th Floor**
400 Deaderick Street
Nashville, TN 37248-3200

The Authorization to Vendor form should be completed as follows:
State Agency Name: DHS-Adult Protective Services
Program Name: Adult Foster Care
Allotment Code: 345.49
Cost Center: APFC

DPA#: 05-02157-00 and document APS client's name on the bottom line.
Vendor: (Should match information on the Sponsor's Invoice)
Items Authorized: Use the three lines to detail Emergency Board payment, Service Fee and/or Special Transportation amounts.
Dates of Service: (Should match dates on the Sponsor's Invoice submitted).
Units Authorized: One month or number of days if less than a month.
Unit Cost: Monthly Rate or pro-rated amount per day if less than a month.
Amount Authorized: (Equals the amount entered in Sub-Total column on the Sponsor Invoice).
Effective Date: (Use starting date of placement contract)
State Agency Authorization: DHS-Adult Protective Services, APS staff name, title, signature, and date.
Vendor Acceptance: Sponsor's name and signature (as it appears on the placement contract), and date.

Requests for payment to an Adult Family Home Sponsor should be submitted on the attached **APS-Adult Foster Care Sponsor Invoice.**

Payee information which is needed includes:

- the name of the sponsor
- their vendor ID number
- the address of the residence where the APS client is located
- the county where the resident is located
- a phone number where the sponsor can be reached
- the APS client's name, social security number, date of birth, and the case ID number
- the period of time covered by this invoice should reflect the beginning and ending dates
- the contract number should be entered as **DP-05-02157-00**

Monthly rate for the Service Fee is $220. The dates of service should match or be within the time frames entered in the "For Period" section. The Sub-Total amount reflects the monthly rate multiplied by one month or the portion of the month the service was provided. Sub-Total amounts are added to find the Total Payment due to the sponsor.

APS continues to have an exemption that authorizes state employees and officers to provide Adult Foster Care Services. If the sponsor is a state employee or officer, the placement contract should include Attachment #1 to *Adult Placement Contract, HS-0071*.

15-18-07 Revised Contracts, Refunds, Cancellations and Adjustments

Revised contracts are required anytime the board rate changes. Any revisions to the contract other than routine board/service rate changes which would result in changes to the standardized placement contract **must** be referred to the State Office and the DHS Legal Division.

Whenever an overpayment has been made, a refund must be requested and the overpayment must be recovered by the DHS Fiscal Services Unit. If the sponsor is not due the full amount of a check issued by the Fiscal Services Unit, the DHS Fiscal Services Unit should be contacted by telephone (615-313-6697) for instructions. The check may be held pending further instructions, cancelled for the entire amount, or cancelled and reissued for a partial amount.

15-18-08 Instructions for Computing Board Payments and Payments for Services

Payments to sponsor(s) are set by the Department based on the current standard SSI payment. Payment for which the resident is responsible are computed based on the following instructions:

Board Payments – The resident pays $458 per month to the sponsor.

Payment of Service – Payment for service is $220.00 per month and will be paid by the Department except in cases in which the resident has a monthly income in excess of $674. In these instances, the resident will retain $216 to cover clothing, medical, and personal incidental costs. He/She will pay the sponsor the current board rate and pay the balance to the sponsor in excess of the $674 as a portion of the payment for service up to the maximum of $220.00 per month. If the resident's income is not sufficient to cover the entire service fee, then the Department will pay the balance due to the sponsor.

EXCEPTION: If a resident does not have TennCare then he/she may retain an additional $20.00 per month (total $236) prior to making a payment on the payment for service. A monthly income of $914 without TennCare or $894 with TennCare will allow the resident to pay the full payment of the service fee.

The following examples indicate the methods of computing the correct portion of the "Payment for Service" to be paid by the resident based on the income of the resident:

SSI Only Income

1. Mr. Smith receives $674.00 SSI (only income) he would then:
   - Pay sponsor: Board $458 and
   - Retain for self $216.00
   - DHS would pay sponsor: $220.00 - Payment for services

SSI and TennCare, Plus Social Security and Unearned Income then Resident Pays Part of the Service Fee

2. Mrs. Jones receives $693.00 Social Security + $1.00 SSI (has TennCare) she would then:
   - Pay sponsor: Board $458.00 and
   - Payment for service $ 20.00
   - Retain for self $216.00
   - DHS would pay sponsor: $200.00 - Payment for services

No SSI, No TennCare and Income from Other Sources

3. Mr. Brown receives $714.00 Social Security (or retirement or other income, but no SSI or TennCare) he would then:
   - Pay sponsor: Board $458.00 and
   - Payment for service $ 20.00
   - Retain for self $236.00
   - DHS would pay sponsor: $200.00 - Payment for services

Adequate Income for Resident to Pay all of the Service Fee and Keep Additional Money for Self

4. Mrs. Clark receives $914.00 retirement income (without SSI or TennCare) she would then:
   - Pay sponsor: Board $458.00 and
   - Payment for service $220.00
   - Retain for self $236.00
   - DHS would pay sponsor: $none - Payment for services paid in full by the resident

15-18-09 **Income Tax Status**

Sponsor(s) should be advised to discuss with the Internal Revenue Service (IRS) the amount of the board payment and/or service fee that may be considered by IRS to be taxable income.

Sponsor(s) should keep records to show the expenses they have in connection with the family home program. Family home care is not usually considered as an income producing venture, as the payment received by the sponsor is used to meet the resident's needs. However, if there is a net profit it may be to the sponsor's advantage to increase his social security coverage by paying the self-employment tax.

15-18-10 **Liability**

The family home sponsor is an independent contractor (service provider) and is not an agent of the State. Therefore, the sponsor may be liable in the event of accidental injury or death of the resident occurring in the family home, on the sponsor's property, or in his/her automobile. Sponsor(s) should be encouraged to consider the purchase of liability insurance with their home owner and automobile insurance policies.

15-19 PROCEDURES FOR PLACEMENT AND SUPERVISION

15-19-01 **Purpose**

The purpose of placement and supervision procedures is to insure the provision of proper care for adults in family homes and the provision of continuous active support to the sponsor family in carrying out the task of giving quality care to residents.

15-19-02 **Pre-Placement Activities**

a. Selection of Family Homes

To achieve the best possible placement and to locate the family home that will most adequately meet the needs of the client it will be necessary to carefully consider the following factors:

1. **The needs of the client and the ability of the particular sponsor to meet those needs.** Consideration should be given not only to the physical setting of the home but also the services the prospective sponsor can offer in order to meet the client's needs.

2. **The compatibility of personalities.** Consideration should be given to the emotional needs of both the client and the prospective sponsor, as well as, the ability of each to be accepting, understanding and flexible.

3. **Availability of community resources.** The client's need to be in close proximity to specific community resources, near former associates or in a familiar neighborhood should be considered.

4. **Standard of living.** There is a possibility that the client would be uncomfortable in a setting that is economically far above or far below that to which he/she is accustomed.

5. **Difference in lifestyles.** The ability of the sponsor and the client to accept differences in lifestyles should be considered. Expressed preferences of sponsor families either for or against particular characteristics of residents should be considered. As an example, persons who express a dislike for smoking may find it impossible to have a warm and accepting attitude toward the person who smokes. The placement has a better chance to be successful if the client's personality, characteristics, and habits can be accepted by the sponsor family. The reverse would also hold true with regard to the client's acceptance of the sponsor's individual differences.

6. **Discrimination Prohibited.** A sponsor cannot reject a resident for placement on the basis of race, age, sex or solely on the basis of handicap. Decisions regarding placement should be based on the sponsor's ability to provide the care required by the client's condition.

7. **Information Shared.** Sponsor(s) should be given general information about the prospective resident under consideration for placement and given an opportunity to make a decision as to whether they wish to consider the person further. Information to be provided at that time shall include:
   - general health - special needs in regard to diet; medication; physician's services; etc.
   - personality profile;
   - community services desired, i.e., recreation, social, religious, etc.

Concurrently, the adult for whom a family home is being sought should be provided information about the home and sponsor(s) for his/her consideration. Information to be shared with him/her shall include:

- family makeup, including personalities;
- physical facilities;
- community.

8. **Preplacement Visit.** After the counselor has given information to both the client and the prospective sponsor about the other, if there are any areas of doubt these should be weighed against areas of special strength or merit. If both parties are interested in further consideration, the client should visit the family home at least once, preferably more. A weekend or overnight visit is a good idea. If circumstances prevent a pre-placement visit, the case record must clearly document the reason that a pre-placement visit was not made.

15-19-03 Preparing the Client for Placement

In many instances the resident will be receiving regular medical care, and a report of the condition and medical needs should be requested by the APS counselor. When medical information is not available, any available insurance, Tenncare, Medicaid, Medicare or indigent medical services, or the resident's income must be used to pay for an examination.

When it has been determined that family home care should be considered for a particular client, the counselor should explain to the client and interested members of his/her family how the program operates. The client should be informed about what can be expected in terms of services, companionship, help and support, the sponsor family's expectation of the client, the mutual obligations, and the agency's role in the arrangement.

The preceding section, **Section 15-19-01(1)** Selection of Family Homes, includes information regarding the client's visits to the prospective family home prior to placement.

15-19-04 Placement and Initial Follow-Up Visits to Assess Resident's Adjustment

The decision to make a placement shall be made with the concurrence of the potential resident, sponsor(s) and counselor.

At the time of placement, *Adult Placement Contract, HS-0071,* which sets forth the agreement reached between the Department, the sponsor(s) and the resident, is signed by each.

The ACSS input form on the APS client should be changed when an adult is placed in a Family Home and should be coded **"L"**. The counselor should also prepare in duplicate, *Emergency Information about Adult in Family Home Care, HS-1667,* give the original to the family home sponsor, and file a copy in the client's case record. The counselor and the family home sponsor will need to share with each other information either receives that would require a change on the Form 898. Each should make the necessary change(s) on their respective copy and note the date of the change(s).

During the initial period of placement, the resident and sponsor family will need regular guidance and support from the counselor. The counselor's concern should be related to those areas which affects the adequate functioning of the resident, primarily his/her physical comfort and health, his/her reactions to the change and his/her new relationships and activities.

Minimum standards should include a first visit to the home when the client arrives and a follow-up within a week after placement.

At least monthly visits should be planned until the placement has stabilized. Visits may need to be made more often, possibly on a weekly basis for a few months.

15-19-05 Supervision of the Placement

The counselor should endeavor to develop the foundation for a good three-way relationship involving the resident, the sponsor family, and the counselor, when the placement is made. If the placement is to be successful, the counselor must offer help to both the resident and the sponsor family, allowing time to see the family home sponsor(s) and the resident separately. Joint interviews may be used in addition to separate interviews.

As a matter of courtesy and respect for the rights of others, supervisory visits should be made by appointment, except in rare instances. Consideration should be given to the following during supervisory visits:

1. Physical arrangements to ensure that the family home sponsor is maintaining the required standards regarding meals, furnishings, safety, etc. The physical comfort of the resident can also be an

important factor in determining how readily he/she adjusts to the placement.

2. The resident's reaction to the change and/or adjustment to the family home setting. There may be a tendency to withdraw or find fault with everything. Adjustment may come very slowly. The counselor and the sponsor will need to combine their efforts to find ways to reassure and help the resident with the problems brought on or aggravated by the change.

3. Health care of the resident will be another concern of the counselor and the sponsor family. It is the counselor's responsibility to have at the time of placement, information about the resident's physical and mental condition and a recommendation from the physician as to a day-to-day routine regarding health and information as to when check-ups are necessary. It is the sponsor family's responsibility to see that the prescribed regimen is followed and to help the resident make and keep necessary appointments for medical care.

4. The attitude of the sponsor family toward the disabled and elderly must be considered. If for instance, the sponsor family regards an elderly or disabled person as a child; the resident will not be given the opportunity to assume the role of an adult in the family setting, which will defeat a principal goal of family home care. The sponsor family needs enough information about the resident's usual behavioral pattern to be able to recognize changes that need to be reported to the Department.

   Accidents, unusual sickness and disturbing behavior always need to be reported. Prompt response to the sponsor family's requests for help may prevent more serious problems later, but the family and resident should be encouraged to settle minor problems among themselves.

5. It is important not to lose sight of the sponsor family; they provide for, live with, and care for the resident 24 hours a day. It is a taxing responsibility both physically and mentally. Appreciation for the job being done should be conveyed by both the counselor and other staff of the Department.

   - Monthly visits are required until the placement is stabilized. As a general rule, visits with sponsors and residents should continue on a monthly basis. However, quarterly visits may be

considered in some cases when no changes are expected and the following conditions exist:

- There is a full and careful evaluation of the placement, i.e., the counselor knows the resident and the sponsor(s).
- There is a determination of the resident's medical, psychiatric and/or social needs and abilities based on evaluations and reports by appropriate professionals.
- There is a determination that the supervision and care provided by the sponsor(s) is adequate, based on the resident's needs.
- There is a determination that the resident has made good adjustment/progress in the family and is receiving appropriate services.

15-19-06 **Structure of Supervision**

It is helpful to schedule visits with the sponsor at a time convenient to the family. Consulting the family about the timing of visits is also a way of conveying recognition and respect. When visiting, the counselor should also allow sufficient time to see both the sponsor family and resident separately.

The relationship between the counselor and the sponsor family serves two purposes. One purpose is that of authority and expectation. There is an agreement between the Department and the sponsor family to provide meals, furnishings and arrangements related to safety, etc. and the counselor needs to be firm in his/her expectation that the sponsor family maintain standards.

Tangible evidence of acceptance of the sponsor family as individuals is needed if the second purpose, a sound basis for cooperation between the Department and sponsor is to be achieved.

Unless the counselor's firmness is balanced with acceptance of the sponsor family's right to function within the framework of its own way of life, the relationship may remain unproductive.

The sponsor family should be encouraged to treat the resident with the same respect and courtesy that would be shown to any adult. The resident should not be surrounded by the kind of concentrated attention which

smothers initiative leaving little or no room for making choices or decisions.

If the emphasis is for the resident to have an opportunity to continue in family living, then he/she like everyone else within the family setting is given a meaningful role. What is important, in terms of supervision of the home is helping the sponsor family choose the "niche" where the resident will fit, where he/she will neither be shielded nor burdened unnecessarily.

If a resident suffers a form of chronic illness or becomes ill, the sponsor family should know how to reach both the counselor and the physician. They should not hesitate to call the counselor whenever there is doubt about medical resources. Established routines in the family's way of functioning may enter into the picture, such as the use of home remedies which may or may not be appropriate in the given situation. The sponsor family must be discouraged in the administration of non-prescribed medicines, but on the other hand, the family must help the resident at all times to follow the doctor's recommendations regarding prescribed medicines.

The presence of a resident for 24-hours daily inevitably will spark areas of conflict in the sponsor family. Friction occurring because of minor disagreements or transgressions of established routines is best handled by the parties themselves. As a matter of fact, the family and the resident should be encouraged and helped to settle any differences between themselves. The counselor should not permit himself/herself to become a "mediator" during such times.

When behavioral changes take place because of illness and disturbances result, the sponsor family should be given help in dealing with the changes and try to prevent either unnecessary panic or neglect. At times it may be advisable to help the sponsor family tolerate disturbances for a while; at other times the sponsor family may need help in accepting the necessity for the resident to go on to a different living arrangement.

If the placement has to be terminated, either because of a drastic change in the client's physical condition or sudden behavioral disturbances, members of the foster family will need the worker's active support. The family may feel obligated to continue care against all odds out of a sense of guilt at failure or because of their attachment to the resident. Such situations require sensible and sensitive handling.

15-19-07 **Methods of Supervision**

a. Individual Supervision

The counselor's relationship with the sponsor family is a combination of educational and casework techniques with periodic emphasis upon one or the other.

b. Group Supervision

In counties with several family homes the group method for supervision may be helpful. The criteria used for selection of group members vary, but those most frequently used are neighborhood, number of clients in the home, or newness of the home.

These groups, conducted largely on the educational level, discuss broad topics such as nutrition, physical and mental health, recuperation, and rehabilitation methods. It is helpful if the meetings can be held with the participation of specialists on a variety of topics. Meetings may deal with agency-sponsor family relationships, mutual expectations, responsibilities, and obligations. Discussion of various resources in the community and ways of using them is also important and helpful.

While mainly educational in nature the group meetings also serve another function. They help to develop among the sponsor families best sources for locating additional family homes.

15-19-08 Termination of Placement

If a placement is to be terminated, whether at the request of the resident or sponsor family, or for some other reason, advance notice should be given to all parties concerned. Sponsors who wish to terminate a placement must give thirty (30) days notice to the Department in order to allow time for adequate plans to be made for the resident. The counselor should assume an active role and endeavor to minimize any negative effects that may be expected to result from the resident's move, especially if the move is being made because the placement has not been successful.

Any change in placement of a client may be a difficult experience for the resident and the sponsor family. Both may need understanding and support from the counselor. Many times moving a resident who has become a part of the family can be detrimental to the resident and the family. Before moving a resident, great care should be taken to consider the emotional attachment of both the resident and the sponsor family.

Whether the resident is moving into another protected environment or to an independent arrangement will require preparation to facilitate a smooth transition into a different living arrangement. The resident's family and

friends, when possible, should be encouraged to participate in planning and should also be informed of any changes in living arrangements.

The case file of the resident, as well as the sponsor's file, should clearly reflect any change or termination of placement.

15-19-09 Temporary Absence from Family Home

When the resident is temporarily out of the home (such as for hospitalization), and the counselor agrees that returning to the family home is the appropriate plan for the resident, payment of the service fee may be continued for a maximum of 30 days, provided the following conditions exist:

1. The resident makes a definite decision that he/she wishes to return to the family home.

2. The resident agrees to make payment to the sponsor family for the time he/she is away from the home.

3. The sponsor family agrees to reserve the space for the resident.

To continue payment of service fees beyond 30 days will require approval by the DHS District Administrator or a designee.

15-19-10 Death of a Resident in Care

Most of the persons going into family care will have health problems that will be under control. It is therefore likely and conceivable that a resident could die while in family home care. The counselor should be particularly sensitive to the needs of the sponsor family should death occur. This could be a very upsetting experience for the sponsor family. The counselor should offer them help and support after the resident's death.

Before a person is placed in family home care, the counselor will give the family some guidelines to follow in the event of death.

It is anticipated that many residents will have burial insurance. The resident should inform some member of the sponsor family where he/she keeps his/her burial policy. If a member of the resident's family has the policy, the sponsor family will need to know how to get in touch with that person. Information regarding the policy and the name of the person who has the policy will be recorded by the counselor on *Emergency Information About Adults in Family Home Care, HS-1667*.

If a resident does not have burial insurance it would be desirable to obtain insurance before placement in a family home. Even though the counselor cannot tell the resident how to spend his/her money, the resident should be advised of his/her need for burial insurance. Many times, however, due to the resident's age or existing health problems, he/she may not be able to obtain insurance, or he/she may find that the premium costs are higher than he/she can afford to pay.

Each counselor will need to be familiar with the county procedure for the burial of a person without insurance or other source of funds. There should also be a definite procedure to be followed by the sponsor family in notifying the counselor or the Department in the event of death of the client on weekends or at night when the county office is closed. This information should be provided on *Emergency Information About Adults in Family Home Care, HS-1667*.

15-19-11 Use of Other Services in Conjunction with Family Home Care

Family home sponsors are responsible for providing care and supervision for resident's 24-hours per day. Care of the resident outside the family home for part of the day may be needed to make the home situation tolerable for the sponsor family and preserve the placement. Care outside the home may be beneficial to the resident who exhibits behaviors that would indicate a need for specialized interventions, i.e., adult daycare, shelter workshop, or day treatment. Training in self-help skills and personal care may be needed by a resident who has a handicap condition as well as training directed toward eventual employment or independent living.

15-20 RECRUITMENT OF FAMILY HOME SPONSORS

A large part, and a difficult one, of establishing a program to provide family home care for adults will consist of informing the community about the program and recruiting the homes. Recruitment of family homes for adults calls for some of the same kind of procedures used in finding foster homes for children, though there are numerous differences in requirements of the two programs. The prospective provider of family home care for adults may be of any adult age bracket, homes of single individuals may be suitable, persons having health problems that are under control (for instance, diabetes, arthritis, or heart trouble) may be used, requirements regarding physical arrangements of the home are different, etc. In spite of these and other differences, families who are already giving foster family home care to adults offer some of the best resources for recruiting. Their experience enables them to provide concrete help in locating suitable homes, as well as, interpreting the program to the community from a realistic point of view.

15-20-01 Methods of Recruitment

Agency workers who, by virtue of having lived in the community or worked there for any period of time, often have intimate knowledge of neighborhoods and individual families who could be used for first contacts. Others who might have valuable contributions to make in this respect would include ministers, operators of rural stores, neighborhood doctors, extension service workers and leaders of women's organizations. If these informal efforts do not lead to enough family homes to fill the need, appeals should be directed to other social agencies, church and synagogue congregations, and civic organizations.

The problems involved in finding suitable homes will vary from one area to another and plans, therefore, must be tailored to individual communities and groups within the community. Persons within the community must be made aware of the program's existence and learn enough about it to interest them in getting more details. Numerous methods and combinations of methods may be employed:

- Newspaper articles, newspaper feature articles, letters to the editor;
- Radio spot announcements and/or interviews, public opinion shows, talk shows;
- Television spot announcements, local interviews or specials on family home care, coverage on newscasts;
- Cooperation with and interpretation to social service agencies and professionals, such as contacts with senior citizens groups;
- Contact ministers, priests, rabbis, and request that articles/notices be put in church bulletins;
- Talk before civic organizations, and submit articles for newsletters;

Newspaper articles, radio and television spot announcements are viewed as the primary source and the most fruitful sources through which potential applicants learn of the program, but it is beneficial to have applicants exposed to more than one recruitment method.

15-20-02 Newspaper Articles

Local newspapers have been found to be very much interested in supporting community efforts but lose interest after an initial article or two.

It is important, therefore, to make as much use of this initial interest as possible. Follow-up to an initial article is important as very often an individual will read a newspaper article with only passing interest, and a week or so later decide that he/she wants to know more but cannot remember where to call and put off finding out.

If a follow-up article appears a week to ten days later, this problem can sometimes be avoided. There are at least five (5) different ways in which to present the program in a newspaper:

a. Classified Advertising

This approach has not been commonly used as it tends to emphasize the financial motive which we are philosophically and deliberately bound to avoid. It is possible, however, that a small announcement of the program might be helpful in those areas where other forms of newspaper publicity have been exhausted. This approach is most effective if it is signed by a person who is well known in the community and not associated with the agency. An example of wording would be: "Are you looking for a new meaning and purpose for your life?

Why not open your home to a person who has none? Call the Department of Human Services (phone number) and ask about Family Homes for Adults.

b. News Release

This is the type of article that simply announces the existence of a program and tells a little about it, possibly including the agency, name and phone number for persons interested in knowing more. Also, included in this group would be news coverage of presentations to civic groups.

c. Regular Columns

Most newspapers have regular columns on subjects of interest. The columnist usually becomes well-known and develops a following of readers. If the interest of a well-known columnist can be stimulated he/she can be of tremendous help in developing community interest, as his/her approach to the subject will add the human interest touch which is usually lacking in a regular news article. His/her personal endorsement of the family home program will often cause his/her regular readers to consider it more seriously than they might

otherwise. Columnists on the "Women's Page" are often interested in this type of article, but it need not be limited to any particular section of the paper.

d. Letters to the Editor

Writing letters for publication on the editorial page of a local newspaper is a little used, but often effective way to reach the more educated, or at least more informed reader. This approach is most effective if the letter is signed by a person who is well known in the community, but not associated with the agency. A local doctor, lawyer, politician, or judge who is interested in the program would be excellent, but the worker or supervisor responsible for recruitment will have to seek out the help of such persons and educate them with regards to the goals of the program. Often they will agree to let an agency representative draft the letter for their signature.

e. Feature Article

This is by far the most effective form of newspaper publicity but it is also the most difficult to obtain. These articles often appear in "Sunday Supplements" or family sections of the newspapers and almost always include human interest items and pictures. They go into a considerable amount of detail and local units which are fortunate enough to be given such space are encouraged to obtain consultation from district or state operation. Care should be taken to obtain in writing the permission of the resident and sponsor family if their pictures and names are to be used in a published story.

15-20-03 **Radio**

Radio exposure can be a useful tool for getting the Adult Family Home story to the community. There are two general ways of using radio time:

a. Spot Announcements

This approach probably reaches the greatest number of people, but often does not stimulate as much interest as is needed. It involves preparing a thirty second spot announcement designed to encourage listeners to call for additional information. Radio stations will usually donate time several times a day for several days, and will help with wording the announcement if requested. The tape can be cut by an agency representative, but a professional announcer may be available for this if needed.

b. Interviews or Discussion Programs

This approach is wide open to innovation. Most radio stations have time periods set aside during which they interview individuals concerning items of local interest. An agency representative or possibly even a family home resident could be interviewed with questions designed to cover important points. A panel discussion is another possibility, using a group of sponsors or community leaders and professionals. The possibilities are endless, but the radio station will not usually approach the agency. The local agency representatives must go to the station manager and arouse his/her interest in the program.

15-20-04 **Television**

Television time is often difficult to obtain, but Federal regulations require the stations to give some time for community service announcements. These spots are usually equivalent in content to radio spots, but a poster of some kind will be needed to display on the screen during the announcement. Many local television stations have daytime interview programs similar to those on radio. The educational television stations are particularly good for this type of presentation.

15-20-05 **Church Groups**

Religious organizations of all denominations provide an excellent source of prospective foster homes. Exploration of this area should begin by interviewing local ministers, priests and rabbis to inform them of the program from the pulpit or he/she can usually recommend specific groups within the church organization who might be interested in knowing more about the program.

15-20-06 **Civic Groups**

There are hundreds of local organizations around the state that are constantly looking for luncheon speakers and community service projects. The various women's clubs, garden clubs, and service organizations are an excellent place to start. Some of these have newsletters and most will welcome agency representatives as luncheon or dinner speakers.

15-20-07 **Existing Family Homes**

Many times the Family Home Program will recruit for itself once a number of good homes have been established and placements made. Sponsors

are considered one of the best sources for new family homes and may become active home finders among their acquaintances and friends. This resource is an important one to cultivate when working with sponsors from day to day.

15-20-08 **Senior Citizens Agencies or Retirement Groups**

Senior citizens' agencies or retirement groups should not be overlooked as a source for locating prospective family homes. By far, the largest percentage of family homes is offered by widows. Widows or retired individuals may consider family home service because of a desire to be needed, or the companionship of having someone else in the empty house.

15-20-09 **Family Assistance Recipients**

One other possible source for good family homes is the family assistance recipient. Much caution must be used in selecting candidates, but a limited number of recipients would make excellent sponsor families. Although their income is limited, some have demonstrated that they can function adequately on what they have and would not be considered to be dependent upon the family home payment for support.

15-20-10 **Adult Family Home Pamphlet - "Family Homes for Adults"**

The pamphlet, Family Homes for Adults should be available in every county office. It is not intended to tell the whole story, but it can stimulate interest if properly used.

Any location where people gather can be considered for distribution of the pamphlet. Many ministers will allow them to be placed in church lobbies. Any number of social agencies and associations may display them. Visiting nurses' associations and some doctors could produce any number of possibilities.

FORMS USED IN FAMILY HOMES FOR ADULTS PROGRAM

The following forms are used in the Family Homes for Adults Program:

HS-2832	(FA) Authorization for Release of Information
HS-2431	Fire Safety Checklist for Family Homes for Adults
HS-0066	Medical Report - Adult Family Home
HS-0069	Report of Physician's Examination for Resident of Family Home for Adults
HS-0070	Application to Provide A Family Home for Adults
HS-0071	Adult Placement Contract
Attachment #1 To HS-0071 - Adult Placement Contract	
HS-1667	Emergency Information About Adult Family Home Care
HS-1143	Financial Information for Adult Family Home Sponsor(s)
HS-2858	APS-Adult Foster Care Sponsor Invoice
HS-2859	Authorization to Vendor (APS only)