COMMONWEALTH OF MASSACHUSETTS
DISABLED PERSONS PROTECTION COMMISSION
ABUSE REPORTING FORM

Please call 1-800-426-9009 to file an oral report.
This form should be returned within 48 hours of the oral report.
Mail to: DPPC, 300 Granite Street, Suite 404, Braintree, MA 02184
Fax to: (857)403-0296 Attn: Hotline
Or email to: DPPChotline@massmail.state.ma.us

For Department Use Only:

Case #: _____
Referral Agency: _____
Screening Decision: _____
Oversight Officer: _____
Date Received: _____

REPORTER INFORMATION:

Name: Click here to enter text. **Occupation:** Click here to enter text.
Agency: Click here to enter text. **Address:** Click here to enter text.
Telephone #: Click here to enter text.
Alternate Telephone#: Click here to enter text.

INFORMATION ON THE ALLEGED VICTIM OF ABUSE:

Name: Click here to enter text.
Address: Click here to enter text.
Tel. #: Click here to enter text.
DOB or approximate age if DOB not known: Click here to enter text. **Gender:** ☐ **M** ☐ **F**
Social Security Number: XXX-XX-Click here to enter text.
Preferred language or communication needs: Click here to enter text.
Disability: Click here to enter text.
►**What assistance does the person require because of his/her disability:** Click here to enter text.
Agency served by: Choose an item.

DESCRIPTION OF ABUSE:

Description of the incident of alleged abuse and/or condition of neglect. (Include names, dates, times, and specific facts and any information regarding prior incidents of abuse/neglect): Click here to enter text.

OTHER DETAILS:

►**Describe any injuries in detail, including size, shape, location, etc. Indicate any medical treatment required:** Click here to enter text.

►**Describe any emotional injury and how it affected the Victim's ability to function:** Click here to enter text.

►**If abuse is sexual in nature, were police notified (name of department) and was medical treatment provided?** Click here to enter text.

►Who was responsible for the care and supervision of the Victim at the time of the incident?
Name Click here to enter text. **Telephone #:** Click here to enter text.
Relationship/position: Choose an item.

►Is there something that the victim's caretaker could have done to prevent the incident?
Please describe: Click here to enter text.

ALLEGED ABUSER INFORMATION:

►Person alleged to have abused or neglected the Victim:
Name: Click here to enter text.
Telephone#: Click here to enter text.
Address, if known: Click here to enter text.
DOB or approximate age if DOB not known: Click here to enter text. **Gender:** ☐ **M** ☐ **F**
Social Security Number: XXX-XX-Click here to enter text.
Relationship to the Victim (i.e. relative, direct care staff, another client, etc): Choose an item.
►Does this person provide any care or assistance to the Victim? Please explain the nature of the assistance provided: Click here to enter text.

COLLATERALS:

►Persons or agencies involved or knowledgeable about the Victim:
1. Name: Click here to enter text.
Relationship: Click here to enter text. **Agency:** Click here to enter text.
Telephone #: Click here to enter text.

2. Name: Click here to enter text.
Relationship: Click here to enter text. **Agency:** Click here to enter text.
Telephone #: Click here to enter text.

RISK:

►Does the person alleged to have abused the Victim still have access to or caretaker responsibility for the Victim? Explain: Click here to enter text.

►What actions have already been taken to protect the Victim from further abuse or neglect? Click here to enter text.

►Do you believe that the Victim is at continued risk of harm? If so, what actions need to occur to protect the Victim? Click here to enter text.

►What is the current location of the ALV:
Address: Click here to enter text.
Telephone #: Click here to enter text.
Program name (if applicable): Click here to enter text.

Was an oral report filed: ☐ **Yes** ☐ **No**
If not, please call (800)426-9009 to file an oral report.
If so, indicate date and time filed. Date: Click here to enter a date. **Time:** Click here to enter text.
****PLEASE ATTACH ADDITIONAL INFORMATION IF NECESSARY.**

Click here to enter text.	Click here to enter a date.	Click here to enter text.
Signature of Reporter	**Date**	**Time**