Confederated Tribes of the Chehalis Reservation

Social Services

Elder & Vulnerable Adult Intake / Safety Concern Form

This form may be completed by community members, family members, service providers, or agencies to report concerns regarding the safety, well-being, or care of an elder or vulnerable adult. ***Please e-mail to referrals@chehalistribe.org***

I. PERSON OF CONCERN (ELDER / VULNERABLE ADULT)

Name: _____

Date of Birth: _____ Age: _____

Tribal Affiliation / Enrollment (if known): _____

Address / Location: _____

Phone Number (if known): _____

Living Situation: ☐ Alone ☐ With Family ☐ Caregiver ☐ Facility ☐ Other: _____

II. REPORTER INFORMATION

Your Name: _____
Relationship to Individual: ☐ Self ☐ Family ☐ Friend ☐ Community Member ☐ Provider
☐ Other: _____
Phone Number: _____
Email: _____@ ☐gmail.com ☐chehalistribe.org ☐ yahoo.com
☐ Hotmail.com ☐ comcast.net ☐ icloud.com
☐ Other: _____

May we contact you for additional information? ☐ Yes ☐ No
How would you prefer to be contacted? ☐ E-mail ☐ phone call
Do you wish to remain anonymous? ☐ Yes ☐ No (*please note that information may be shared in court*)

III. REASON FOR INTAKE / SAFETY CONCERN Please check all that apply:

☐ Physical abuse or injury
☐ Medical or mental health concerns
☐ Lack of basic needs (food, housing, utilities, medical care)
☐ Financial exploitation
☐ Sexual abuse
☐ Unsafe living conditions
☐ Emotional or verbal abuse
☐ Self-neglect
☐ Neglect
☐ Caregiver concerns

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☐Other: _____

IV. DESCRIPTION OF CONCERN

Please describe the concern or situation in as much detail as possible (what happened, when, where, and who is involved):

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V. IMMEDIATE SAFETY

- Is the individual in immediate danger**?** ☐ Yes ☐ No ☐ Unsure
- If yes, has 911 or law enforcement been contacted? ☐ Yes ☐ No

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VI. ALLEGED PERSON(S) OF CONCERN AGAINST VULNERABLE ADULT/ ELDER (If applicable)

Name: _____

Relationship to Individual: _____

Contact Information (if known): _____

VII. ADDITIONAL INFORMATION

- **Are there any known medical, cognitive, or mobility concerns?** ☐ Yes ☐ No ☐ Unsure
  If yes, please describe:

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Are there other agencies involved? ☐ Yes ☐ No ☐ Unsure

☐ Tribal Police ☐ Behavioral Health

☐ Chehalis Tribal Court ☐ Chehalis Tribal Wellness Center

☐ Chehalis Tribal Loan fund (Financial Exploitation)

Other: _____

VIII. CONSENT

I understand that this information will be shared with Chehalis Tribal Social Services for the purpose of assessing safety and providing appropriate support.

Signature: _____

Date: _____

IX. FOR SOCIAL SERVICES USE ONLY

Referred To (APS/Other): _____
Immediate Action Taken: _____

Date Received: _____ Received By: _____
Case Number: _____ Time Received: _____

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