**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

**REPORTER INFORMATION:**

| Name: _______________________________ | Occupation: _______________________________ |
| Agency: ___________________________ | Address: _____________________________________ |
| Telephone #: _________________________ | Alternate Telephone#: _____________________ |

**INFORMATION ON THE ALLEGED VICTIM OF ABUSE:**

| Name: _______________________________ |  |
| Address: _______________________________________________________________ |  |
| Tel. #: _____________________________________________________________ |  |
| DOB or approximate age if DOB not known: _________ | Gender: _________ |
| Preferred language or communication needs: ____________________________ |  |
| Disability:__________________ |  |
| ►What assistance does the person require because of his/her disability: ________________ |  |
| Agency served by: _____________________________ |  |

**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):

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OTHER DETAILS:

► Describe any injuries in detail, including size, shape, location, etc. Indicate any medical treatment required: __________________________________________________________
______________________________________________________________________________

► Describe any emotional injury and how it affected the Victim’s ability to function: __________________________________________________________

► If abuse is sexual in nature, were police notified (name of department) and was medical treatment provided? __________________________________________________________
______________________________________________________________________________

► Who was responsible for the care and supervision of the Victim at the time of the incident?
Name:_________________________ Telephone #:____________________
Relationship/position:________________________

► Is there something that the victim’s caretaker could have done to prevent the incident? Please describe: __________________________________________________________
______________________________________________________________________________

ALLEGED ABUSER INFORMATION:

► Person alleged to have abused or neglected the Victim:
Name:____________________________________ Telephone#:____________________________
Address, if known:_____________________________________________________________
Relationship to the Victim (i.e. relative, direct care staff, another client, etc):________________________

► Does this person provide any care or assistance to the Victim? Please explain the nature of the assistance provided: ________________________________
______________________________________________________________________________

COLLATERALS:

► Persons or agencies involved or knowledgeable about the Victim:
1. Name ________________________ Relationship ________________ Agency: ____________________________
Telephone #: __________________

2. Name ________________________ Relationship ________________ Agency: ____________________________
Telephone #: __________________
RISK:

► Does the person alleged to have abused the Victim still have access to or caretaker responsibility for the Victim?

► What actions have already been taken to protect the Victim from further abuse or neglect?

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

► What is the current location of the ALV:
  Address:_________________________________________________
  Telephone #:___________________________________________
  Program name (if applicable): _______________________________

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:__________ Time:_________

**PLEASE ATTACH ADDITIONAL INFORMATION IF NECESSARY.

___________________________________              ______________
Signature of Reporter              Date              Time