Commission for the Protection of Persons with Disabilities
M.G.L. c. 19C / 118 CMR
Abuse Reporting Form

Instructions: This form should be filed with the Commission for the Protection of Persons with Disabilities within 48 hours of filing an oral report.

Methods of Submission:

Email: CPPDhotline@mass.gov

Fax: (857) 403-0296

Mail: CPPD, 300 Granite Street, Suite 404, Braintree, MA 02184

If you have not filed an oral report, please call 1-800-426-9009.

REPORTER INFORMATION

First Name: Last Name:

Street Address:

City/Town: State: Zip Code:

Telephone Number:

Email:

Agency:

Association/Relationship to Alleged Victim:

INFORMATION ON THE ALLEGED VICTIM OF ABUSE

First Name: Last Name:

Street Address:

City/Town: State: Zip Code:

Telephone Number:

DOB:

Gender Identity: Male Female Transgender

Primary Disability:

Acquired Brain Injury
Blind/Visual Impairment
Deaf/HOH
I/DD
Mental Illness
Physical Disability

Other Disabilities or Medical Conditions:

Primary Language/Method of Communication:

Is Alleged Victim aware that a report is being made? Yes No

Type of assistance required by the Alleged Victim need due to his/her disability (indicate all that apply):

Personal care (bathing, toileting, dressing, feeding)
Ambulation
Transfers
Transportation
Special diet/food prep
Money management
Residential care
Day/vocational/clubhouse program care
Job coach/skills training
Inpatient psychiatric care
1:1 supervision
Medication administration
Supervision
Total care
None

DESCRIPTION OF THE ALLEGED ABUSE

Setting Where Abuse Occurred:

Provider/Vendor Location:

Other:

Name of Provider/Vendor:

Address:

City/Town: State: Zip Code:

Telephone Number:

Provide Description of the Alleged Incident(s) *(include names, dates, times, and specific facts and any information regarding prior incidents of abuse)*

DESCRIPTION OF INJURIES SUSTAINED

Physical Injuries *(provide description of injury, including size, color, location, bleeding, etc.)*

Do you have photos of the injuries: Yes No

Emotional Injuries *(Describe how this has impacted the Alleged Victim's ability to function. How is this different form the ALV's baseline behavior? How long did this change in behavior last?)*

INFORMATION ON THE ALLEGED ABUSER

First Name: Last Name:

Street Address:

City/Town: State: Zip Code:

Telephone Number:

DOB:

Gender Identity: Male Female Transgender

Primary Language/Method of Communication:

Relationship of the Alleged Abuser to the Alleged Victim (i.e. direct care staff, family members, peer):

Type of Assistance that the Alleged Abuser provides to the Alleged Victim (indicate all that apply):

Personal care (bathing, toileting, dressing, feeding)
Ambulation
Transfers
Transportation
Special diet/food prep
Money management
Residential care
Day/vocational/clubhouse program care
Job coach/skills training
Inpatient psychiatric care
1:1 supervision
Medication administration
Supervision
Total care
None

Does the Alleged Abuser have continued access to the Alleged Victim? Yes No

PERSONS OR AGENCIES INVOLVED OR KNOWLEDGEABLE ABOUT THE ALLEGED VICTIM OR THE INCIDENT:

Name:

Relationship:

Telephone Number:

RISK

Current location of the Alleged Victim:

Provider/Vendor Location:
Other:

Name of Provider/Vendor:

Address:
City/Town: State:
Zip Code: Telephone Number:

Do you believe the Alleged Victim is at immediate risk of serious harm or injury?
Yes No

What actions do you believe need to be taken to protect the Alleged Victim?

What actions have already been taken to protect the Alleged Victim?

Is medical treatment required immediately? Yes No

If Sexual Abuse has the Alleged Victim been taken to a SANE site? Yes No
If yes, name of SANE site:

Does the Alleged Abuser still have access to the Alleged Victim? Yes No

Is the Alleged Victim able to call for help or access 911 if necessary? Yes No

Have the Police been notified? Yes No

If yes, what actions were taken?

Law Enforcement Contact Name:

Telephone Number:

ADDITIONAL INFORMATION OR COMMENTS

VERIFICATION

Was an oral report filed with CPPD's Hotline? Yes No

Date Filed: Time Filed: AM/PM Case Number:

If you have not filed an oral report, please call 1-800-426-9009 to do so.

Signature of Reporter:
Print Name:
Date: