13.9 REPORT OF ABUSE OR NEGLECT OF ELDERS AND ADULTS WITH A DISABILITY. The Bidder shall immediately make a verbal report of suspected cases of abuse or neglect of elders and adults who have a disability and provide a written report within forty-eight (48) hours to the Bureau of Adult Protective Services, DSC or its contracted Service Provider of Guma Serenidad with a Crisis Intervention Hotline. (Ref. P.L. 31-278, Title 10 GCA, Chapter 2).

13.10 REPORT OF ABUSE OR NEGLECT OF CHILDREN. The Bidder shall immediately make a verbal report of suspected cases of abuse or neglect of children and provide a written report within forty-eight (48) hours to the Child Protective Services Unit, Bureau of Social Services Administration (Ref. P.L. 20-209, Title 10 GCA, Chapter 88).

13.11 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). The Bidder shall comply with the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 and the Federal "Standards for Privacy of Individually Identifiable Health Information" promulgated under 45 CFR Part 160 and Part 164, Subparts A and E.

13.12 SOCIAL SECURITY NUMBER CONFIDENTIALITY ACT. The Bidder shall ensure compliance relative to preventing the inappropriate disclosure and misappropriation of Social Security numbers (Ref. P.L. 28-95, Title 5 GCA, Chapter 32, Article 7).

13.13 CLIENT CONFIDENTIALITY. The Bidder shall ensure information obtained directly or indirectly from clients be kept confidential and cannot be released in a form that identifies the client without the informed consent of the client, or of his or her legal representative, unless the disclosure is required by court order, or for program monitoring by authorized Federal, State or local monitoring agencies (P.L. 31-278 § 2959 Confidentiality).

13.14 PROGRAM TRANSITION. All steps shall be taken by the Bidder to ensure a smooth and professional transition of the program to prevent any interruption of services to the clients and to preserve the integrity of the program.

a. The Bidder, who has not been awarded a new contract or renewal of an existing contract under the program, shall immediately prepare to relinquish all program related information, files, equipment, service contributions, and program income balances and all other operational, administrative, and service documents and/or items to the new Bidder. The Bidder shall designate a person(s) who will work with the DPH&SS, DSC, BAPS in the transition process to the new Bidder.

b. The DPH&SS, DSC shall oversee the transfer of all program related information, files, equipment, monies, etc., to the new Bidder.

13.15 FINANCIAL MANAGEMENT SYSTEM. The Bidder shall ensure the organization possesses a financial management system that meets the standards of the Common Rule for Uniform Administrative Requirements for Grants and Cooperative Agreements with State and Local Governments in financial reporting, accounting records, internal control, budget control, allowable cost, source documentation, and cash management. The Bidder shall ensure their accounting system shall permit timely development of all necessary cost data in the form required by the DPH&SS, DSC and is in accordance with generally accepted accounting principles (Ref. Title 5 GCA, Chapter 5, Article 3, Part E, §5236).

13.16 FILES AND RECORDS MAINTENANCE. All files and records pertaining to the program, both programmatic and financial, shall be accurate and complete and made accessible to the DPH&SS, DSC and are, at a minimum, subject to audit, monitoring, and evaluation.

13.17 MONITORING. Unannounced monitoring of the program by the DPH&SS, DSC shall not be denied by the BIDDER. Monitoring may include, but is not limited to, on-site observations of activities and/or staff, facility inspections, and discussions with clients regarding the effectiveness of the program. All documents related to the operations and delivery of services is subject to review by the DPH&SS, DSC.

13.18 EVIDENCE OF PAYMENT. The Bidder shall ensure a copy of confirmation of payment received through Electronic Funds Transfer (EFT) or copies of check and or check stubs to confirm payment of program invoices shall be provided to the DPH&SS, DSC within twenty-four (24) hours of receipt.

13.19 There shall be a special monthly extension period after the final renewal term on a month to month basis (each being a "Monthly Extension Period"), to begin immediately after the expiration of the final renewal period, provided that in no event may the parties agree to more than six (6) Monthly Extension Periods. The Monthly Extension Periods may be agreed to by the parties only if the Government is unable to continue the services uninterrupted under a new contract after a new solicitation and procurement undertaken by the Government.

The term of contract and special Monthly Extension Period, are subject to the availability of funds from fiscal year to fiscal year and the Government's determination of its best interest.

In the event funds are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal period, the contract shall be canceled and the contractor shall be reimbursed for the reasonable value of any non-recurring costs incurred by not amortized in price of supplies or services delivered under the contract.

14.0 AUDIT

14.1 The Office of Management and Budget (OMB) Circular and guidance requires a non-profit organization shall be subject to the audit requirements contained in the Single Audit Act Amendments of 1996 and the most current OMB Circular A-133.

14.2 A *for-profit* organization is required to comply with Title 45 CFR, Part 74.26(D) of the CFR which incorporates the thresholds and deadlines of the most current OMB Circular A-133 but provides *for-profit* organizations two options regarding the type of audit that will satisfy the audit requirements. The *for-profit* organization may either have: A *Financial-Related Audit* as defined in, and in accordance with, the Government Auditing Standards, commonly known as the "Yellow Book", (GPO Stock #020-000-00-265-4) of all the HHS awards; or An *Audit* that meets the requirements of OMB Circular A-133.

14.3 The Bidder shall prepare and provide to the DPH&SS, DSC within 30 days upon official notification of award of this IFB, a copy of their engagement with a Certified Public Accountant firm to perform the independent audit of the ENP. This audit shall be completed and forwarded to the DPH&SS, DSC, no later than March 31st proceeding September 30th of each contract term.

14.4 The Bidder shall prepare and provide supporting documents to resolve any questioned costs or material weaknesses identified in the annual audit.

14.5 The Bidder is responsible for any questioned costs not resolved at the end of the Agreement year and remains the responsibility of the Bidder awarded said Agreement, even if the Bidder is not awarded the new IFB. The amount due resulting from any questioned costs shall be due to the DPH&SS, DSC within ninety (90) days upon notification by the DPH&SS, DSC, unless otherwise agreed upon by the DPH&SS, DSC and the Bidder.

14.6 The Bidder is responsible for any questioned costs not resolved which shall result in a deduction in the contractual amount of the entire amount questioned from the agreed upon value of the negotiated Renewal or the negotiated new Agreement awarded to the same Bidder.

14.7 The Bidder on which the contract expires shall submit the annual audit to the DPH&SS, DSC no more than six (6) months after the end of the contract's expiration. This provision is specific to the final service year for the program and is not to be misconstrued as to negate the requirement of submitting the annual audits for the first four (4) service years.

The above Program Bid Specifications were drafted by personnel of the DPH&SS, DSC to include, but not limited to the Senior Citizens Administrator, Social Services Supervisor I, and Social Worker III.

Reviewed By:

EVELYN O. CRUZ
Social Worker III

6/3/15
Date

Reviewed By:

JOCELYNN DR CRUZ
Social Services Supervisor I

6/3/15
Date

Reviewed By:

ARTHUR U. SAN AGUSTIN, MHR
Senior Citizen's Administrator

06-02-15
Date

Approved By:

JAMES W. GILLAN
Director, DPHSS

6-3-15
Date

PROGRAM REPORT

GUMA SERENIDAD

FY-201_

MONTH:	SELECT ONE:			
	☐ OCT	☐ JAN	☐ APR	☐ JUL
	☐ NOV	☐ FEB	☐ MAY	☐ AUG
	☐ DEC	☐ MAR	☐ JUN	☐ SEP

REVIEWED BY:	NAME OF BIDDER'S PROGRAM MANAGER & SIGNATURE:
APPROVED BY:	NAME OF BIDDER'S PROGRAM DIRECTOR & SIGNATURE:
SUBMITTED BY:	SERVICE PROVIDER'S NAME:
DATE OF SUBMISSION:	

INVOICE FY-201_

FROM: BIDDER'S NAME Guma Serenidad	ADDRESS:	INVOICE NO.	DATE:
TO: Department of Public Health and Social Services 123 Chalan Kareta Mangilao, Guam 96913-6304	ORDER OF AGREEMENT NO. Account # _____ Contract # _____ Vendor # _____		

ITEM NO.	ARTICLES OF SERVICES	QUANTITY	UNIT	AMOUNT
	Guma Serenidad Services for the month of:			
			TOTAL:	$ -

Services have been rendered satisfactorily

_____ Administrator, Division of Senior Citizens _____ Date

I CERTIFY that this invoice is correct, just, and that payment therefore has not been received.

_____ Signature of Payee _____ Date

Allotment Charge:

_____

_____

CONCURRED BY:

_____ DPH&SS Director _____ Date

APPROVED FOR PAYMENT:

_____ Certifying Officer, DPH&SS _____ Date

DSC 201_ - Invoice

FY-201_ ACCOUNTS RECEIVABLE ACTIVITY REPORT
BIDDER'S NAME
GUMA SERENIDAD

FOR THE MONTH ENDING:

MONTH	INVOICE NUMBER	MONTHLY RECEIVABLES		YEAR-TO-DATE PAID	
		AMOUNT	BALANCE DUE	AMOUNT	BALANCE DUE
October 201					
November 201					
December 201					
January 201					
February 201					
March 201					
April 201					
May 201					
June 201					
July 201					
August 201					
September 201					
TOTAL AMOUNT			$ -		$ -

FY-_____ EXPENDITURE REPORT
BIDDER'S NAME
GUMA SERENIDAD

FOR THE MONTH ENDING: _____

PERSONNEL & BENEFITS COSTS (110/111) *As Transferred from Page 2	ADMINISTRATIVE COSTS		SERVICE EXPENDITURES		TOTALS	
	CURRENT	CUMULATIVE	CURRENT	CUMULATIVE	CURRENT	YTD CUMULATIVE
Subtotal (110/111)						
CONTRACTUAL (230)						
Subtotal (230)						
SUPPLIES AND MATERIALS (240)						
Subtotal (240)						
EQUIPMENT (250) (under $5,000)						
Subtotal (250)						
UTILITIES (360)						
Subtotal (360)						
GRAND TOTAL						

DSC 201_ Expenditure Report

FY- 201_ EXPENDITURE REPORT OF PERSONNEL COSTS
BIDDER'S NAME
GUMA SERENIDAD

FOR THE MONTH ENDING: _____
Pay Period Start/End Dates: _____

Employee Name	Position Title	Position No.	Total Hours Worked this Pay Period	Hourly Rate	Salary Earned this Pay Period	FICA Taxes	Health & Welfare Benefits Earned this Pay Period	Health & Welfare FICA Taxes	Total Salary & Benefits Paid to Employee this Pay Period
Totals (Transfer to Monthly Expenditure Report):									

DSC 201_ Expenditure Report of Personnel Costs

FY-201_ PROGRAM INCOME REPORT
BIDDER'S NAME
GUMA SERENIDAD

FOR THE MONTH ENDING:

PROGRAM INCOME REPORT

*PLEASE SPECIFY	MONTHLY CONTRIBUTIONS		YEAR-TO-DATE CONTRIBUTIONS	
	CASH	IN-KIND (CASH VALUE)	CASH	IN-KIND (CASH VALUE)
CARRYOVER OF UNEXPENDED PROGRAM INCOME			$	
*VOLUNTARY CONTRIBUTIONS MONETARY /GIFTS and DONATIONS				
*FUNDRAISING ACTIVITIES				
*GRANTS				
TOTAL AMOUNT (CASH)	$		$	
*IN-KIND CONTRIBUTIONS (As applicable)		$		$
TOTAL AMOUNT (IN-KIND VALUE)		$		$

FY-201_ PROGRAM INCOME EXPENDITURES REPORT
BIDDER'S NAME
GUMA SERENIDAD

FOR THE MONTH ENDING:

PLEASE SPECIFY	ADMINISTRATIVE COSTS		SERVICE EXPENDITURES		TOTAL CURRENT	TOTAL YTD CUMULATIVE
	CURRENT	CUMULATIVE	CURRENT	CUMULATIVE		
PERSONNEL COSTS (110/111)						
SUBTOTAL (110/111)						
TRAVEL (220)						
SUBTOTAL (220)						
CONTRACTUAL (230)						
SUBTOTAL (230)						
SUPPLIES AND MATERIALS (240)						
SUBTOTAL (240)						
EQUIPMENT (250) (UNDER $500.00)						
SUBTOTAL (250)						
MISCELLANEOUS (290)						
SUBTOTAL (290)						
UTILITIES (360)						
SUBTOTAL (360)						
CAPITAL OUTLAY (450) (ABOVE $500.00)						
SUBTOTAL (450)						
GRAND TOTAL						

FY 201_ MONTHLY STATISTICAL REPORT
BIDDER'S NAME
PROGRAM: GUMA SERENIDAD

MONTH: _____

***DUAL = Elderly with a Disability**

A.	COUNT FOR ADMISSIONS	ELDERLY	ADULT	DUAL	TOTALS
1	Previous Month Client Count				0
2	New Clients Admitted				0
3	Total Unduplicated Clients Served YTD (Add lines 1 & 2)	0	0	0	0
4	Persons on Waiting List				0

B.	COUNT FOR REFERRALS / INTAKES	APPROPRIATE			INAPPROPRIATE			TOTALS
		Elderly	Adult	Dual	Elderly	Adult	Dual	
1	Previous Month Referrals/Intakes							0
2	New Referrals/Intakes							0
3	Total Unduplicated Referrals/Intakes YTD (Add lines 1 & 2)	0	0	0	0	0	0	0

C.	ELDERLY / DUAL CASE STATUS	PREVIOUS MONTH					CURRENT MONTH					YTD TOTALS (Types of Abuse)
	Type of Abuse	ACT +	SUB	UNS	INA	PNG	ACT =	SUB	UNS	INA	PNG	
1	Physical	0					0					0
2	Sexual	0					0					0
3	Emotional or Psychological	0					0					0
4	Financial or Property	0					0					0
5	Neglect	0					0					0
6	Self-Neglect	0					0					0
7	Abandonment	0					0					0
8	Other	0					0					0
9	**Total for the Month**	0	0	0	0	0	0	0	0	0	0	**Total Active Cases YTD**
10	**Previous Month Total**						0	0	0	0	0	
11	**Total YTD**	0	0	0	0	0	0	0	0	0	0	0

D.	ADULTS WITH A DISABILITY CASE STATUS	PREVIOUS MONTH					CURRENT MONTH					YTD TOTALS
	Type of Abuse	ACT +	SUB	UNS	INA	PNG	ACT =	SUB	UNS	INA	PNG	
1	Physical	0					0					0
2	Sexual	0					0					0
3	Emotional or Psychological	0					0					0
4	Financial or Property	0					0					0
5	Neglect	0					0					0
6	Self-Neglect	0					0					0
7	Abandonment	0					0					0
8	Other	0					0					0
9	**Total for the Month**	0	0	0	0	0	0	0	0	0	0	**Total Active Cases YTD**
10	**Previous Month Total**						0	0	0	0	0	
11	**Total YTD**	0	0	0	0	0	0	0	0	0	0	0

E.	UNITS OF SERVICE	PREVIOUS MONTH	CURRENT MONTH	YTD TOTALS
1	Case Management (1Hour)			0
2	Personal Care (1 Hour)			0
3	Outreach (1Contact)			0
4	Hotline Calls (Per Call)			0
5	Nutritional Services (1 Hour)			0
6	Info. & Asst. (1 Contact)			0
7	**Total for the Month +**	0	0	**Total Units of Service YTD**
8	**Previous Month Total =**		0	
9	**Total YTD**		0	0

FY 201_ MONTHLY STATISTICAL REPORT - *PAGE 2 of 3*
BIDDER'S NAME
PROGRAM: GUMA SERENIDAD
MONTH: _____

F. PARTICIPANT ETHNICITY	REFERRALS/INTAKES															ADMISSIONS								
	APPROPRIATE						INAPPROPRIATE						Current Month Total by ethnic group +	Prior Month Total =	YTD by ethnic group							Current Month Total by ethnic group +	Prior Month Total =	YTD by ethnic group
	Elder		Adult		Dual		Elder		Adult		Dual					Elder		Adult		Dual				
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female				Male	Female	Male	Female	Male	Female			
1 Alaskan													0		0							0		0
2 American Indian													0		0							0		0
3 Black													0		0							0		0
4 Chamorro													0		0							0		0
5 Chinese													0		0							0		0
6 Chuukese													0		0							0		0
7 Filipino													0		0							0		0
8 Hawaiian													0		0							0		0
9 Hispanic													0		0							0		0
10 Japanese													0		0							0		0
11 Korean													0		0							0		0
12 Kosraean													0		0							0		0
13 Marshallese													0		0							0		0
14 Pohnpean													0		0							0		0
15 Palauan													0		0							0		0
16 Yapese													0		0							0		0
17 White													0		0							0		0
18 Other (specify)													0		0							0		0
19 Other (specify)													0		0							0		0
20 Other (specify)													0		0							0		0
21 Other (specify)													0		0							0		0
22 Other (specify)													0		0							0		0
23 TOTAL MONTH	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0	0	0	0			
24 PRIOR MONTH																								
25 TOTAL YTD	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0	0	0	0			

Note: For October of each Fiscal Year, all admissions (including carryover from prior Fiscal Year) will be indicated under Prior Month Totals.

FY 201_ MONTHLY STATISTICAL REPORT - *PAGE 3 of 3*
BIDDER'S NAME
PROGRAM: GUMA SERENIDAD
MONTH: _____

G.	SOURCE OF REPORTS (Source: National Center on Elder Abuse 2004 Adult Protective Services Data Survey)	Elderly	Adults	Dual	Current Month Total by Source +	Prior Month Total =	YTD by Source
1	Anonymous / Undisclosed				0		0
2	Aging Network Service Providers				0		0
3	Attorneys				0		0
4	Bankers				0		0
5	Clergy				0		0
6	Dentists				0		0
7	Developmental Disability Staff				0		0
8	EMT / Firefighters				0		0
9	Family Members				0		0
10	Friends / Neighbors				0		0
11	Guardian / Caregiver				0		0
12	Home Health Staff				0		0
13	Housing Agency / Landlord				0		0
14	Law Enforcement				0		0
15	Long-term Care Staff				0		0
16	Long-term Care Ombudsman				0		0
17	Mental Health Staff				0		0
18	Nurses / Nurses' Aides				0		0
19	Paid Caregivers				0		0
20	Pharmacists				0		0
21	Physicians				0		0
22	Psychologists				0		0
23	Self				0		0
24	Social Services Agency Staff				0		0
25	Social Workers (Private Practice)				0		0
26	Other:				0		0
TOTAL REFERRALS RECEIVED THIS MONTH PER CLIENT CATEGORY		0	0	0			

H. CITIZENSHIP		U.S.				NON-U.S.		
		Previous Month	Current	YTD		Previous Month	Current	YTD
		YTD	0	0		YTD	0	0

FY-201_ NON-EXPENDABLE PROPERTY INVENTORY UNDER $5,000.00 IN VALUE
BIDDER'S NAME

PROGRAM NAME: Guma Serenidad
LOCATION:
DATE OF INVENTORY REVIEW:

PAGE _____ of _____

ACQUIRED DATE (a)	ITEM DESCRIPTION (b)	QTY	MAKE MODEL (c)	SERIAL NUMBER (d)	UNIT COST (e)	PURCHASED LEASED OR DONATED (f)	PURCHASED/ LEASED WITH PROGRAM FUNDS OR PROGRAM INCOME (g)	LOCATION (h)	CONDITION (i) (New, Fair, Poor)			% OF PROGRAM USE (j)	COMMENTS
									N	F	P		

INVENTORY PREPARED BY: _____ _____
SIGNATURE AND DATE POSITION TITLE

INVENTORY VERIFIED BY: _____ _____
SIGNATURE AND DATE POSITION TITLE

INVENTORY CERTIFIED BY: _____ _____
SIGNATURE AND DATE POSITION TITLE

FY-201_ NON-EXPENDABLE PROPERTY INVENTORY OVER $5,000.00 IN VALUE
BIDDER'S NAME

PROGRAM NAME: Guma Serenidad
LOCATION:
DATE OF INVENTORY REVIEW:

PAGE _____ of _____

ACQUIRED DATE (a)	ITEM DESCRIPTION (b)	QTY	MAKE/MODEL (c)	SERIAL NUMBER (d)	UNIT COST (e)	PURCHASED LEASED OR DONATED (f)	PURCHASED/ LEASED WITH PROGRAM FUNDS OR PROGRAM INCOME (g)	LOCATION (h)	CONDITION (i) (New, Fair, Poor)			% OF PROGRAM USE (j)	COMMENTS
									N	F	P		

INVENTORY PREPARED BY: _____ SIGNATURE AND DATE _____ POSITION TITLE

INVENTORY VERIFIED BY: _____ SIGNATURE AND DATE _____ POSITION TITLE

INVENTORY CERTIFIED BY: _____ SIGNATURE AND DATE _____ POSITION TITLE

FY- 201_
BIDDER'S NAME
GUMA SERENIDAD

MONTHLY PROGRAM REPORT

Month – Year

PROGRAM REPORT:

Monthly Reports with transmittal page signed by the Program Director and Program Manager shall be complete, accurate, and received by the DPH&SS, DSC in the format provided no later than ten (10) working days after the end of each reporting month, with the exception of the September Reports that are due no later than five (5) working days after the end of the fiscal year and shall include:

A. Staff Trainings, Workshops, Conferences and Presentations (include names of staff and volunteers, dates, titles, presenters and locations)

B. Complaints, Problems and Concerns, and Proposed Solutions:

1) From Clients
2) From Aging Providers
3) Vehicles: List of all Government Owned Vehicles not used for a consecutive period of 48 working hours and the reason for their non-use.
4) Routes: Report separately Assisted Transportation Services and Transportation Services.
5) Other (Specify)

C. Program Accomplishments: Provide a description highlighting the achievements of the program (Provide a narrative description of results achieved for the reporting month)

D. Plans for Next Month

1) Staff Training Plan
2) Management Plan
3) Special Activities
4) Presentations and Outreach Plan

FY – _____ TRANSMITTAL PAGE

GUMA SERENIDAD

YEARLY (PLEASE ATTACH THE FOLLOWING):

- ☐ RELEASE OF CLAIMS STATEMENT
- ☐ NON-EXPENDABLE PROPERTY INVENTORY LISTING (OVER & UNDER $5,000.00)
- ☐ LISTING OF ALL STAFF REFLECTING CRIMINAL HISTORY RECORD
- ☐ LISTING OF BANK ACCOUNTS

REVIEWED BY:	NAME OF BIDDER'S PROGRAM MANAGER & SIGNATURE:
APPROVED BY:	NAME OF BIDDER'S EXECUTIVE OR PROGRAM DIRECTOR & SIGNATURE:
SUBMITTED BY:	SERVICE PROVIDER'S NAME:
DATE OF SUBMISSION:	

FY- _____ YEARLY REPORTS
NAME OF BIDDER
GUMA SERENIDAD

Month – Year

Yearly Reports shall be complete, accurate and received by the DPH&SS, DSC no later than five (5) working days after the end of the fiscal year and shall include:

1) Release of Claims Statement.

2) Non-Expendable Property Inventory Listing shall be certified by its certifying officer [Ref. P.L. 29-19, Section 6, (d)] to include:

   (a) Date of Purchase or Lease;

   (b) Item Description;

   (c) Make/Model;

   (d) Serial Number;

   (e) Unit Cost;

   (f) Indicate whether purchased, leased, or donated;

   (g) Indicate whether purchased or leased with Program Funds or Program Income;

   (h) Physical Location of Item/Object;

   (i) Condition of Item/Object; and

   (j) Percentage of Program Usage of Item/Object.

3) Listing of all staff reflecting Criminal History Record (Police Clearance) of Felony Arrest(s) or Conviction(s) that occurred within the past seven (7) years, dates of Felony Arrest(s) or Conviction(s) and employment date of staff. The list provided by the Service Provider shall include traffic citations and violations.

4) Listing of bank accounts, such as checking, savings, time certificates of deposit, money market accounts, etc., of funds from transportation services including information of activities from which the funds were generated, authorized signatures and current balances (Service Contributions).

FY 201_ Yearly Report

FY-201_ RELEASE OF CLAIMS STATEMENT

CONTRACT: BIDDER'S NAME _____

PROGRAM NAME: GUMA SERENIDAD _____

CONTRACT NO.: _____

KNOWN ALL MEN BY THESE PRESENTS:

In consideration of the promise and the sum of, the total amount of which will not exceed lawful money of the United States of America and _____ of which has been paid and _____ of which is to be paid by the Government of Guam under the above mentioned contract, the undersigned Contractor does, and by the receipt of said sum shall, for itself, its successors and assigns, remise, release and forever discharge the Government of Guam, its officers, agents and employees of and from all liabilities, obligations and claims whatsoever in law and equity under or arising out of said contract.

IN WITNESS WHEREOF, this release has been executed this _____ day of _____, 201_.

WITNESS:

_____ PRINT NAME

_____ SIGNATURE

_____ CONTRACTOR

BY: _____

TITLE: _____

CERTIFICATE

I, _____, certify that I am the _____ of the Corporation as Contractor in the foregoing release; that _____ who signed said release on behalf of the Contractor was the _____ of the Corporation by authority of its governing body and is within the scope of its corporate powers.

_____ NAME AND SIGNATURE

DATE: _____

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM

INSTRUCTIONS

Title III reporting requirements provide statistical data for management and advocacy initiatives serving as indicators for new and continued funding of programs for seniors. The data collected is used for budget justifications, congressional inquiries, program development and mandated reports for federal, state and local agencies. Information must be accurate for it to be useful in supporting program services.

- **FORM:** This form is an Intake, Profile and Referral (IPR) Form, and not an Assessment Form. Profile characteristics are used in developing new programs to meet the needs of the elderly. Each Service Provider may have their own Assessment Form for their specific programs.
- **DATA RETENTION:** Client data is inputted and retained in a main registry.
- **SSN:** If a client does not provide a Social Security Number (SSN) then leave the space blank.
- **INCOME LEVEL:** The Income Level is based on the U.S. Department of Health and Human Services Poverty Guidelines and shall be completed before the Intake, Profile and Referral Form can be processed.
- **PRIORITIZATION OF SERVICES:** Based on the need to activate prioritization of services, the number of persons to be served will be determined by the existing conditions of clients enrolled in a program and those on a wait list at the time of implementation. Information on mobility, support system, housing condition, activities of daily living, health status and financial assets is collected should prioritization of services be necessary.
- **REFUSAL TO ANSWER:** Should a client refuse to answer a certain question, leave it blank. In the comments section, list the reason for not answering the question. This does not apply to Income Level.
- **SIGNATURE:** The signature of the client or responsible party is required before services can be provided.
- **SPECIAL ACCOMMODATIONS:** Clients requiring special accommodations shall inform the program in advance of their requirements.
- **PROGRAM SPECIFIC INFORMATION:**

- **Case Management Services.** Case Management Services Program, at a minimum, conducts an assessment to individuals requesting Adult Day Care Services, In-Home Services and Home-Delivered Meals. Entry into these programs shall not be permitted before an assessment is made and eligibility established by Case Management Services.
- **Transportation Services.** In order to meet demands, clients requesting transportation shall make reservations with the Transportation Services Program in advance for service. If the date requested cannot be accommodated, the Transportation Services Program shall recommend an alternate date. Requests for persons using wheelchairs or having a Personal Assistant/Personal Care Attendant shall be made in the same manner, whether for Center participation or to and from medical appointments, etc.
- **Elderly Nutrition Program.** To the extent practicable, meals are prepared to meet special dietary needs of eligible participants, and shall be supported by a statement from the client's doctor or religious leader stating the necessity for special meals. Mechanical (chopped) or pureed (blenderized) meals are not classified as special meals and shall be provided to the client at their request.

FOR ADULT PROTECTIVE SERVICES (APS)
REFERRALS, CALL 735-7421 / 7415
Monday - Friday, 8 a.m. to 5 p.m.
(Except on Recognized Holidays)

OR

EMERGENCY RECEIVING HOME
24-HOUR CRISIS INTERVENTION HOTLINE,
at 632-8853

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

A. CLIENT IDENTIFICATION		
Last Name		
First Name		
Middle Name		
Nickname		
Social Security No.		
Email Address		
Homeless	Yes No	
Receives Care from NFCSP Caregiver	Yes No	
Requires Assistance in an Emergency	Yes *(Specify)*	No
Home Address		
Mailing Address		
Phone (1)		
Phone (2)		
B. CLIENT CONTACTS		
Primary Emergency Contact		
Relationship		
Address		
Phone		
Email		
Physician Contact		
Physician Type		
Address		
Phone		
Email		

Primary Caregiver		
Relationship		
Address		
Phone		
Email		
Personal Contact		
Relationship		
Address		
Phone		
Email		
C. CLIENT DEMOGRAPHICS		
Date of Birth		*Age*
Gender	Male	Female
Disabled	Yes *(Specify Type)*	No
Disability	Permanent Temporary Not Applicable (N/A)	
Physical Disability	*(Specify)*	N/A
Intellectual Disability	*(Specify)*	N/A
Mental Illness	*(Specify)*	N/A
Cerebral Palsy	*(Specify)*	N/A
If < 60 Reason for Service	Caregiver Disabled Meal Volunteer	Other: _____ Spouse N/A
Citizenship *(Specify)*		
Race (Specify)	White Black/African American American Indian/Alaskan Native Asian Native Hawaiian/Other Pacific Islander Other Multiple	

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

DSC INTAKE, PROFILE AND REFERAL FORM (Revised: 01.30.15) All other forms remain obsolete.

Page 1 of 6

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

Ethnicity	*(Specify)*
Primary Language	*(Specify)*
English Fluency	Needs Translation Limited Fluent
Literacy	In English In Main Language In Both Illiterate
Relationship Status	Married Divorced Separated Single (Never Been Married) Widowed Domestic Partner
Employment Status	Full-Time Part-Time Retired Un-Employed Volunteer Disabled
Veteran Status	Veteran Spouse Child No
Urban/Rural	Rural
Housing Type	House/Own House/Rent Apartment/Duplex Residential Care Facility Nursing Facility Other None
Lives With	Alone Family Spouse Non-Relative Other
Referral Source	Self Family/Friend Agency:_____ Other:_____

Sources of Support	Family Friend/Neighbor Paid Help Has help but unsure who provides help Unknown
Assisted Transportation	Yes No
Needs an Escort	Yes No
Primary Transportation	Owns Car Aide Friend Public Transport Senior Transport Family Other None

Income Level

Is your income less than

Unit Size	Per Month	Per Year	Yes	No
One (1)	$1,226.67	$14,720		

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Two (2)	$1,660.00	$19,920		

Is your combined income less than

Unit Size	Per Month	Per Year	Yes	No
Three (3)	$2,0933.33	$25,120		

Four (4) or more in the Unit Size, add $433.33 per month or $5,200 per year for each additional member.

$_____

Income Information	Above 100% FPL At or Below 100% FPL
Financial Assets *(Refer to FAS Scale)*	29% to 49% below the poverty level 50% to 74% below the poverty level 75% or greater below the poverty level N/A

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

DSC INTAKE, PROFILE AND REFERAL FORM (Revised: 01.30.15) All other forms remain obsolete.

Page 2 of 6

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

Receives Social Security	None Retirement Disability Dependent
Receives Private Pension	Yes No
Health Insurance	*(Specify)*
Medicare	Part A Part B Claim No._____ None Part D Claim No._____ None Medicare Supplemental Claim No._____ None
Medicaid	Yes Claim No._____ None
Guardian/ Conservator	None Voluntary Involuntary
Person/ Organization Holding Guardianship/ Conservatorship	
Guardian Conservator Type	Estate Person Both Dementia Power Medical Authority None
Durable Power of Attorney	Unknown Limited Health Both None
Supplemental Nutrition Assistance Program (SNAP)	Yes No

D. CLIENT FUNCTIONAL ASSESSMENT	
Activities of Daily Living (ADL) Choices	
Transfer Mobility	Unknown Independent Supervision Assistance Dependent
Bathing	Unknown Independent Supervision Assistance Dependent
Dressing	Unknown Independent Supervision Assistance Dependent
Toileting	Unknown Independent Supervision Assistance Dependent
Eating	Unknown Independent Supervision Assistance Dependent
Ambulating	Unknown Independent Supervision Assistance Dependent
Assistive Devices *(Specify)*	
Mobility Devices *(Specify)*	

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

DSC INTAKE, PROFILE AND REFERAL FORM (Revised: 01.30.15). All other forms remain obsolete.

Page 3 of 6

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

Communication Skills Status	
Receptive	Unknown Good Fair Poor Does Not Understand
Expressive	Unknown Good Fair Poor Cannot Be Understood
Sensory Skills	
Vision	Unknown Good Limited Legally Blind Blind
	Glasses Other
Hearing	Good Limited Deaf
	Unknown Hearing Aid Other
Support System	Unknown Support is Available Minimum Support No Support
Housing	Unknown Full Concrete Semi Concrete Tin and Wood
Homebound	Unknown Yes No
Bedridden	Unknown Yes No

E. AGING SERVICES REQUESTED

Adult Day Care Services

Elderly Nutrition Program:

Congregate Meals (Center/Day Care)
Home-Delivered Meals (Homebound)

Meal Type:
Regular
Mechanical/Chopped
Pureed/Blenderized
Special (*Provide document from physician or religious leader to certify special meal requirement.*)

Case Management Services

In-Home Services

Legal Assistance Services

National Family Caregiver Support Program

Senior Center Operations

_____
(Specify Center)

Transportation Services

COMMENTS:

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

DSC INTAKE, PROFILE AND REFERAL FORM (Revised: 01.30.15) All other forms remain obsolete.

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

F. HIGH RISK CLIENTS UNDER EMERGENCY DECLARATION

A client is considered High Risk under Emergency Declaration if any of the following exists. This information shall be provided to the client's village Mayor in preparation for emergencies. ***Check all that apply.***

- Bedridden.
- Requires transportation and/or escort assistance for evacuation to shelter, e.g., those living alone.
- Requires refrigeration of medication and/or is insulin dependent.
- Requires oxygen.
- Lives in substandard housing.
- Not Applicable.

G. ELIGIBILITY AND CONSENT OF CLIENT

Individuals age sixty (60) years and older are eligible for Title III programs under the Older Americans Act. This Act also prioritizes services for:

- Persons who are frail, homebound by reason of illness or incapacitating disability, or otherwise isolated; and
- Persons with greatest economic need with particular attention to low-income individuals; persons with greatest social need with particular attention to low-income minority individuals, and those who reside in rural areas.

Voluntary contributions to Title III programs are encouraged and used to expand services. Services may not be denied because the client will not or cannot contribute to the cost of the program.

I CERTIFY THE INFORMATION GIVEN BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND IT WILL BE KEPT CONFIDENTIAL AND USED ONLY TO HELP ME RECEIVE THE BENEFITS/SERVICES WHICH I MAY BE ENTITLED.

I HEREBY AUTHORIZE THE DISCLOSURE AND RELEASE OF THIS INFORMATION ONLY FOR THE PURPOSES FOR WHICH IT IS INTENDED. THIS AUTHORIZATION MAY BE REVOKED BY THE UNDERSIGNED AT ANY TIME BY GIVING WRITTEN NOTICE TO THE PARTIES AUTHORIZED HEREIN.

Signature of Client or Authorized Representative (AR)	
Date	
Relationship to Client, if AR	

H. INTAKE INFORMATION

Intake Worker	
Signature of Intake Worker	
Date/Time of Intake	
Organization	
Phone Number	

IPR Forwarded To

- Case Management Services Program
  - Adult Day Care Program
  - In-Home Services Program
  - Elderly Nutrition Program (Home-Delivered)
- Elderly Nutrition Program (Congregate Meals)
- Legal Assistance Services Program
- Senior Center Operations Program
- Transportation Services Program
- National Family Caregiver Support Program

Forwarded By	
Date Forwarded	
Time Forwarded	

I. RECEIVING ORGANIZATION INFORMATION

IPR Received By	
Date	
Time	
Date of Initial Contact with Client	
Time of Initial Contact with Client	
Time of Intake	
Organization	
Phone Number	

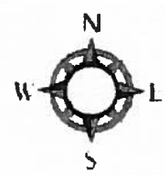
CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

DSC INTAKE, PROFILE AND REFERAL FORM (Revised: 01.30.15) All other forms remain obsolete.

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

J. CLIENT'S HOME		
IF MAP IS SENT SEPARATELY, INCLUDE THE CLIENT'S NAME AND SSN AT TOP OF MAP		
Does the home have an accessible driveway?	Yes	No
If you use a wheelchair, is there an accessible ramp?	Yes	No

MAP TO THE CLIENT'S HOME
In the box below, draw a map to the client's residence marking the client's home with an "X". Indicate the house number, street name and the village where the client is from. Include primary and secondary access roads, type and color of the house, if fenced, landmarks such as adjacent to or across from the village community center, store, bus stop, etc. ***All pets at your home shall be controlled by leash, cage, etc. in accordance with P.L. 22-13 and 26-76.***



CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

DSC INTAKE, PROFILE AND REFERAL FORM (Revised: 01.30.15) All other forms remain obsolete.

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) RECORD CHANGE AND SERVICE UPDATE FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK.

Use of this form will record a change or document a program service update to a client's *Intake, Profile and Referral* form or to the most recent *Record Change and Service Update* form on file. Requested changes should be supported with proper documentation i.e. Marriage Certificate, Mayor's Verification, etc.

Please check ☑ if this is a Record Change or Service Update Change, or both:

	RECORD CHANGE		SERVICE UPDATE CHANGE

Name (Last, First, Middle Initial)	**Date of Birth** (MM/DD/YY)
Guam GetCare Identification Number	**Effective Date of Action** (MM/DD/YY)

For Areas A. B. C. D. E. F, and J. please add additional lines as needed.

A. CLIENT IDENTIFICATION (RECORD CHANGE)

AREA OF CHANGE	FROM	TO

B. CLIENT CONTACTS (RECORD CHANGE)

AREA OF CHANGE	FROM	TO

C. CLIENT DEMOGRAPHICS (RECORD CHANGE)

AREA OF CHANGE	FROM	TO

D. CLIENT FUNCTIONAL ASSESSMENT (RECORD CHANGE)

AREA OF CHANGE	FROM	TO

E. AGING SERVICES REQUESTED (SERVICE UPDATE CHANGE)
Indicate the specific program, and describe the change in service to include effective date of period change, and duration of change.

AREA OF CHANGE	FROM	TO

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

DSC IPR RECORD CHANGE AND SERVICE UPDATE FORM (Revised: 10.17.14) All other forms remain obsolete.

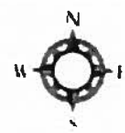
Page 1 of 2

SENIOR CITIZENS AGING SERVICES FY-2015
INTAKE, PROFILE AND REFERRAL (IPR) RECORD CHANGE AND SERVICE UPDATE FORM
PLEASE PRINT CLEARLY USING BLUE OR BLACK INK

F. HIGH RISK CLIENT UNDER EMERGENCY DECLARATION (RECORD CHANGE)		
AREA OF CHANGE	FROM	TO

J. CLIENT'S HOME (RECORD CHANGE)		
AREA OF CHANGE	FROM	TO

DRAW A MAP TO THE CLIENT'S HOME (RECORD CHANGE)
(Indicate primary and secondary access roads, type and color of the house, if fenced, landmarks such as adjacent to or across from the village community center, store, bus stop, etc.)



INTAKE INFORMATION		PROGRAM MANAGER	
Name of Intake Worker		Name of Program Manager	
Signature of Intake Worker		Signature of Program Manager	
Date of Intake		Date of Review	
Organization		**DISPOSITION**	
Aging Program		APPROVED Effective Date: _____	
Contact No.			
Date Forwarded to Program Manager		DISAPPROVED Reason: _____	

CLIENT'S NAME: _____ GETCARE ID: _____ PROGRAM ID: _____
(Last, First, Middle Name)

DSC IPR RECORD CHANGE AND SERVICE UPDATE FORM (Revised: 10.17.14). All other forms remain obsolete.

Page 2 of 2

ADULT PROTECTIVE SERVICES REFERRAL

DIVISION OF SENIOR CITIZENS • DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
123 Chalan Kareta, Mangilao, Guam 96913-6304 Ph: 735-7415 or 7421

Transmittal of this referral form via facsimile is strictly prohibited.
Please print clearly using black or blue ink.

REFERRAL INFORMATION		
Referral taken by:		
Date:		
Time:		
Referring Person:		
	☐	Anonymous *(Enter check ☑ if appropriate)*
Agency:		
Phone No.		
Contact Person:		
Phone No.		

CLIENT INFORMATION				
Client Status: *(Enter check ☑ in appropriate box)*	☐	New	☐	Active
	☐	Former	☐	Deceased: D.O.D.:
	☐	Male	☐	Female
	☐	Elderly	☐	Adult with a Disability
	☐	Elderly with a Disability (Dual)		
Last Name:				
First Name:				
Middle Name:				
Home Address: *(Please include directions, description, landmarks, etc.)* ☐ **Map on back**				
Village:				
Current Physical Location:				
Phone No.				
Ethnicity:				
Citizenship:				
Birth Date				
Age:				
Marital Status *(Enter check ☑ in appropriate box)*	☐	Single	☐	Married
	☐	Widowed	☐	Divorced
	☐	Other:		
Disability:				

TYPES OF ABUSE *(Enter check ☑ in appropriate box)*			
☐	Abandonment	☐	Emotional or Psychological
☐	Financial or Property Exploitation	☐	Neglect
☐	Physical	☐	Sexual
☐	Self-Neglect	☐	Other:

ALLEGED ABUSER INFORMATION				
Last Name:				
First Name:				
Middle Name:				
Relationship:				
Address *(Please include directions, description, landmarks, etc.)*				
Village:				
Phone No.:				
Ethnicity:				
Gender:	☐	Male	☐	Female
Birth Date:				
Age:				
Marital Status: *(Enter check ☑ in appropriate box)*	☐	Single	☐	Married
	☐	Widowed	☐	Divorced
	☐	Other:		

FOR USE BY APS STAFF ONLY				
Case No.				
Referral No.:				
Database Entered by:				
Assigned Worker:				
Date Assigned:				
Reports:	24 Hour / 7 Day:		14 Day:	
	30 Day:		60 Day:	
Continued on back?	☐	Yes	☐	No

(Continued from page 1)

NATURE AND EXTENT OF ABUSE	
EMERGENCY ACTION TAKEN:	☐ **Referred to APS Social Worker on** ***(Enter date & time):***

MAP:

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF SENIOR CITIZENS
ADULT PROTECTIVE SERVICES UNIT

INVESTIGATION REPORT

SECTION I. – VICTIM PROFILE			
Client Name:		Case No.:	
Address:		Contact No:	
DOB:	Age:	Sex:	Category:
SSN:	Ethnicity:	Citizenship:	Type of Abuse:

SECTION II. – ALLEGED ABUSER PROFILE			
Name:		Ethnicity:	
Address:		Contact No:	
DOB:	Age:	Sex:	SSN:
Relationship to Client:		Place of Employment:	

SECTION III. – IMMEDIATE INTERVENTION

Date	Presenting Problem	Intervention

ADULT PROTECTIVE SERVICES
INVESTIGATION REPORT – 7 DAY REPORT

SECTION IV. – VICTIM INVESTIGATION CHRONOLOGY

Client Name:	Case No.:

Date	Narrative

Based on initial contact:

- ☐ Inappropriate
- ☐ Service Plan in place
- ☐ Needs further investigation
- ☐ Undetermined due to:
- ☐ Substantiated
- ☐ Unsubstantiated

Social Worker Signature:		Date:	
Supervisor Review – Signature:		Date:	

ADULT PROTECTIVE SERVICES
INVESTIGATION REPORT

SECTION V. – INITIAL SERVICE PLAN

Client Name: Case No.:

Date	Problem / Goal	Objective / Method

Social Worker Signature: Date:

ADULT PROTECTIVE SERVICES
INVESTIGATION REPORT

SECTION V. – SERVICE PLAN
UPDATES

Client Name:			Case No.:
Date	Problem / Goal	Objective / Method	
Social Worker Signature:		Date:	

ADULT PROTECTIVE SERVICES
INVESTIGATION REPORT – 14 DAY REPORT

SECTION VI. – ALLEGED ABUSER INVESTIGATION CHRONOLOGY

Case Name:	Case No.

Date	Narrative

Social Worker Signature:		Date:	
Supervisor Review – Signature:		Date:	

ADULT PROTECTIVE SERVICES
INVESTIGATION REPORT– 30 DAY REPORT

SECTION VII. – INVESTIGATION CHRONOLOGY

Case Name:	Case No:

Date	Narrative

Social Worker Signature:		Date:	
Supervisor Review – Signature:		Date:	

ADULT PROTECTIVE SERVICES
INVESTIGATION REPORT – 60 DAY REPORT

SECTION VIII. – INVESTIGATION CHRONOLOGY

Case Name:	Case No.

Date	Narrative

Social Worker Signature:		Date:	
Supervisor Review – Signature:		Date:	

ADULT PROTECTIVE SERVICES INVESTIGATION REPORT SECTION IX. – CASE DETERMINATION		
Client Name:		Case No.:
	SUBSTANTIATED: There is sufficient evidence to support the existence of the abuse.	DATE:
	UNSUBSTANTIATED: There is inconclusive evidence of abuse but existence of the abuse cannot be disproved to the satisfaction of the Unit.	DATE:
	NOT DETERMINED WITHIN 90 DAYS *(Explanation **must** follow)*	DATE:

SECTION X. - TRANSFER / DISPOSITION / TERMINATION SUMMARY			
Transfer to:			
	Another APS Worker due to:		
	Emergency Receiving Home Worker due to:		
Disposition:			
	Pending – Case remains open for follow-up and monitoring.		
	Pending – Declaration sent to Office of the Attorney General – Substantiated.		
	Pending – If **No Determination** as of ninety (90) days after receipt of referral, information shall be expunged from Central Registry.		
	Substantiated/Unsubstantiated. **Shall be maintained for ten years.**		
Social Worker:		Date:	
Supervisor:		Date:	
Termination (*Investigation is complete*):			
	Client refused or withdrew consent to conduct investigation.		
	Case closed due to:		
	Case resolved.		
Social Worker:		Date:	
Supervisor:		Date:	

ADULT PROTECTIVE SERVICES UNIT CONTACTS SUMMARY			
Client Name:		Case No.:	
DATE / TIME	PERSON / AGENCY / ORGANIZATION	TYPE OF CONTACT	STAFF INITIALS

PC – Phone Call CC – Collateral Contact CW – Case Write-Up
HV – Home Visit OV – Office Visit

ADULT PROTECTIVE SERVICES UNIT CHRONOLOGICAL ENTRY	
Client Name:	Case Number:
DATE	SUMMARY OF CONTACT

HV – Home Visit
OV – Office Visit
CC – Collateral Contact
PC – Phone Call
CW – Case Write-Up

ADULT PROTECTIVE SERVICES
INVESTIGATION REPORT

INVESTIGATION CHRONOLOGY
UPDATE

Client Name:	Case No.:

Date	Narrative

Social Worker Signature:		Date:	

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF SENIOR CITIZENS
ADULT PROTECTIVE SERVICES UNIT

CENTRAL REGISTRY CASE PROFILE

VICTIM PROFILE

Client Name:					Case No.:	
Address:					Date of Birth:	
Category *(Check (√) as appropriate)*:		Elderly		Adult		Dual

ALLEGED PERPETRATOR PROFILE

Name (s):

SUMMARY

Type of Abuse *(Check (√) as appropriate)*:		Abandonment		Physical		Sexual
		Material/Financial		Mental/Emotional		Neglect
		Self Neglect		Other (Specify):		

DATE	LOCATION OF ALLEGED ABUSE

NATURE AND EXTENT OF ALLEGED ABUSE(S):

PROGRESS OF LEGAL PROCEEDINGS: ☐ ***NOT APPLICABLE***

ADULT PROTECTIVE SERVICES
CONSENT FORM

CONSENT TO CONDUCT INVESTIGATION

This section is protected by Public Law 31-278, Chapter 2, Title 10, Article 10, Section 2957, Guam Code Annotated, Adult Protective Services Unit, relative to Consent of the Victim.

I, _____ hereby give consent to the **Adult Protective Services** to conduct an investigation concerning Case No._____ received on_____(Date)

_____ Signature of Client or Guardian

_____ Witness

_____ Date

_____ Date

WITHDRAWAL OF CONSENT TO CONDUCT INVESTIGATION

I, _____ hereby withdraw my consent for the **Adult Protective Services** to investigate matters relative to the above noted referral.

_____ Signature of Client or Guardian

_____ Witness

_____ Date

_____ Date

REFUSAL TO CONDUCT INVESTIGATION

I,_____ hereby refuse to give consent to the **Adult Protective Services** to conduct an investigation concerning Case No._____ received on _____. (Date)

_____ Signature of Client or Guardian

_____ Witness

_____ Date

_____ Date

GUMA SERENIDAD - CLIENT CONSENT FOR RELEASE OF INFORMATION

This information is being released from records protected by Public Law 31-278, Chapter 2, Title 10, Article 10, Section 2959, Guam Code Annotated, Bureau of Adult Protective Services as contracted to the Project Serenidad, Bidder's Name, relative to Confidentiality.

I, _____ (RELEASING PARTY), hereby give permission to release information to the **Guma Serenidad, Bidder's Name** as contracted by the **Bureau of Adult Protective Services, Division of Senior Citizens, Department of Public Health and Social Services** for the purpose of serving and protecting vulnerable adults age 18 through 59 and seniors, age 60 years and older, as applicable to me or my ward. The information being released is limited to: ***Please be very specific with Releasing Party to initial beside each appropriate item.***

	Social Security Administration					
	SSN#		-		-	

	Personal
	Medical
	Financial

	All information determined to be necessary to assist in the investigation of APS Case No.:	

	Other: (specify)

_____ Signature of Client or Guardian

_____ Witness

_____ Date

_____ Date

GUMA SERENIDAD - REVOCATION OF CONSENT FOR RELEASE OF INFORMATION

I, _____ (RELEASING PARTY), hereby revoke this Consent for Release of Information to the person or organization listed above as of _____.
(DATE)

_____ Signature of Client or Guardian

_____ Witness

_____ Date

_____ Date

GUMA SERENIDAD

AGREEMENT FOR SHELTER SERVICES

I _____, hereby acknowledge the existence of the services which have been explained and discussed with me.

I therefore:

[ ] Accept and will follow all Guma Serenidad rules and regulations during my stay at the shelter.

[ ] Give permission to the shelter staff to conduct business on my behalf.

- [ ] Pick up my medication
- [ ] Take me on shelter activities
- [ ] Take me to and from my doctor's appointments
- [ ] Attend meetings on my behalf
- [ ] Other(s) Specify: _____

[ ] Refuse to give permission to the shelter staff to conduct business on my behalf.

[ ] Would like to be referred to another agency for additional services.

- [ ] Division of Senior Citizens (DSC) – Title III Aging Programs
- [ ] Adult Protective Services (APS)
- [ ] Department of Integrated Services for Individuals with Disabilities (DISID)
- [ ] Department of Vocational Rehabilitation (DVR)
- [ ] Legal Assistance Service (LAS)
- [ ] Other(s) Specify: _____

Signature of Client/Family Member or Guardian	Date:
Signature of Shelter Staff	Date:
Signature of Witness	Date:

GUMA SERENIDAD
CLIENT MEDICAL REPORT

(TO BE COMPLETED BY A PHYSICIAN)

TO THE PHYSICIAN: Please be specific in providing a complete report. Such information is essential in determining proper placement in our **GUMA SERENIDAD.** This will be part of the client's record.

Client's Name:		Date of Admission:
Address:		Date of Discharge:
Phone No.:		Client I.D. Number:
Birthdate:	Client Lives: [ ] Alone [ ] Other Relative [ ] w/Spouse [ ] Non-Relative [ ] w/Children	Social Worker:
Sex: [ ] Female [ ] Male	Marital Status: [ ] Married [ ] Single [ ] Widow [ ] Separated [ ] Divorced [ ] Unknown	
Religious Preference	Racial/Ethnic Background	Highest Level of Education
Family Income	Language Spoken, if not English	Interpreter Needed [ ] Yes [ ] No If yes, what language:
Entitlements [ ] Social Security [ ] TANF [ ] Food Stamps [ ] Other	Health Care Coverage [ ] Medicare Plan A [ ] Medicare Plan B [ ] Medicaid [ ] Other (Specify) _____	Person to contact in an emergency: Phone No.: Preferred Hospital:
Name of Primary Physician:		Name of Alternate Physician:
Address:		Address:
Phone Number:		Phone Number:
Name of Legal Guardian:		Relationship
Address:		Phone Number:

PHYSICAL FINDINGS

(Check those applicable)

A. STATE OF AMBULATION

_____Walks freely without aid, including stairs.
_____Walks with difficulty without aid, including stairs.
_____Walks without aid, but cannot climb stairs.
_____Requires assistance for all walking.
_____Crutches.
_____Wheelchair-bound.

Other qualifying remarks:_____

B. FEEDING

_____Can cut food and feed self.
_____Can feed self, only if food is cut.
_____Must be fed.
_____Tube feeding required.

Other qualifying remarks:_____

C. BOWEL AND BLADDER CONTROL

_____No assistance needed.
_____Could be helped to bathroom when necessary.
_____Condition varies.
_____Requires bedpan or urinal and _____ can ___ cannot request same.
_____Completely incontinent of feces and urine.

Other qualifying remarks:_____

D. SPEECH

_____No difficulty.
_____Language barriers.
_____Dysarthria.
_____Aphasia.

Other qualifying remarks:_____

E. MENTAL STATE

_____No abnormalities.
_____Emotional stability ___presenting _____not presenting problems in management.
_____Mild confusion and memory lapses.
_____Noisy and disturbing to others.
_____Has been in the past an alcoholic or drug addict _____ but not presenting these problems at present time.

Other qualifying remarks:_____

F PERSONAL CARE

_____No assistance needed.
_____Needs help in ___dressing ___ toileting.

Other qualifying remarks:_____

PHYSICAL FINDINGS (continued)

(Check those applicable)

G. PATIENT REQUIRES

_____Close medical care and supervision.
_____Primary nursing care with occasional medical supervision.
_____Simple custodial care (room and board in protected situation) with occasional medical supervision.

Other qualifying remarks:_____

Any special problems such as: _____ deafness _____blindness _____amputation.

Is the patient free from communicable disease? _____Yes _____ No

DIAGNOSIS:_____

PROGNOSIS:_____

RESTORATIVE GOALS:_____

LABORATORY FINDINGS:

Serology_____ CBC_____ Urinalysis_____
Other_____

X-RAY REPORT:_____

RECOMMENDATIONS:_____

SPECIAL DIET:_____

MEDICATIONS:_____

_____ _____
PHYSICIAN'S SIGNATURE DATE

DIVISION OF SENIOR CITIZENS, DPHSS ADULT PROTECTIVE SERVICES UNIT RISK FACTOR ASSESSMENT			
Case No:		**Case Name:**	
FACTOR	**LOW RISK**	**MODERATE RISK**	**HIGH RISK**
A. VICTIM • Physical/Mental Activities	☐ Cares for & protects self without assistance	☐ Requires limited assistance	☐ Completely unable to protect/care for self
• Perception of Risk	☐ Appropriate	☐ Questionable	☐ Inappropriate **If checked, worker must complete a Mental Status Exam.*
• Extent of Abuse	☐ No discernable effect	☐ Safety assured; non-life threatening	☐ Life threatening; injuries require EMS
B. CAREGIVER/ GUARDIAN • Level of Cooperation / Protection	☐ Aware of the problem and cooperative; may deny some responsibility	☐ Limited cooperation; slow to seek help from agencies	☐ Denies problem and refuses to cooperate; vacillates in commitment to protect victim
• Abilities and Control	☐ Realistic perception	☐ Poor reasoning; needs assistance	☐ Poor perception and unwilling or unable
C. ALLEGED ABUSER • Rational Behavior	☐ Accidental injury with	☐ Unintentional minor injury	☐ Intentional with desire to harm
• Level of Cooperation	☐ Cooperates but does so because of authority involved rather than due to interest in victim's welfare	☐ May deny abusive behavior but acknowledge a generalized problem	☐ Likely to move from community; non-cooperative with services in the past
• Access to Victim	☐ No access	☐ Access is difficult; AA makes direct threats on a daily basis to victim's sense of security	☐ Complete access; AA makes direct and dramatic threats to victim's emotional security
• History of Abuse/Neglect	☐ No reported history	☐ Previous history, unsubstantiated	☐ Previous history, substantiated

FACTOR	LOW RISK	MODERATE RISK	HIGH RISK
D. ENVIRONMENT ▪ Home Physical Condition	☐ Clean and no apparent safety/health hazard	☐ Trash/garbage or animal droppings not disposed	☐ Structurally unsound safety/health hazard
▪ Support System	☐ Support available	☐ Some support	☐ No support and isolated
▪ Stress	☐ Stable environment	☐ Financial burden/difficulties	☐ Other crisis in family; lacks support
E. CLIENT'S CAPACITY TO MAKE INFORMED LIFE DECISIONS	☐ Appears reliable to make own decisions at this time	☐ Questionable; needs further assessment; recommend referral to Office of the Public Guardian for review.	☐ Client exhibiting poor insight; lacks understanding of the problem due to decreased cognitive ability; recommend immediate contact with the Guam Police Department and the Attorney General of Guam for assistance and intervention.
F. SEVERITY OF NEGLECT / SELF-NEGLECT	☐ Unkempt appearance; meals irregular, but adequate; no medical / dental care, but with no ill effects; caregiver/AA has periodically not attended to victim's needs	☐ Caregiver/AA reveals frequent inability to care for or protect victim; meals not provided, victim chronically hungry; unattended medical / dental problems causing victim discomfort; some periods of unsupervised care, victim has no access to or knowledge of resources; caregiver/AA avoids interaction with victim to meet emotional needs	☐ Victim is left unsupervised for excess periods of time; neglect results or could result in severe injury or illness; caregiver/AA consistently withholds affection and rejects victim; significant developmental delays due to neglect
Notes:			
Social Worker conducting Assessment:		**Date/Time of Assessment:**	

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF SENIOR CITIZENS

PROCEDURES FOR REPORTING ABUSE OF THE ELDERLY OR ADULTS WITH DISABILITY

Public Law 31-278 delineates the policy for the reporting of abuse of the elderly and adults who have a disability. As stated within the law, the following definitions pertain:

a. **Adult with a Disability** - Any person eighteen(18) years or older who:

   1. Has a physical or mental impairment which substantially limits one or more major life activities of daily living.

   2. Has a history of, or has been classified as having an impairment which substantially limits one or more major life activities.

b. **Major Life Activities** - Include, but are not limited to: caring for oneself, performing manual tasks, standing, walking, seeing, hearing, eating, sleeping, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking and working.

c. **Elderly** - A person age sixty (60) years or older.

d. **Caregiver** - Any family member or any person, health facility, community care facility, clinic, home health care agency or legal guardian who has the care or custody of the elderly or adult with disability who has been abused.

e. **Elderly or Adult with a Disability Abuse** - Means self-neglect or any one (1) or more of the following acts inflicted on an elderly or adult with a disability by other than accidental means by another person: physical abuse, neglect, or abandonment.

The following definitions apply:

a. **Abandonment** - The desertion of an elderly or adult with a disability by his or her caregiver under circumstances in which a reasonable person would continue to provide care or custody.

b. **Emotional or Psychological Abuse** - Includes fear agitation, confusion, severe depression, or other forms of serious emotional stress that is brought about by forms of intimidating behavior, threats, harassment, or by deceptive acts or false or misleading statements made with malicious intent to agitate, confuse, frighten, or cause severe depression or serious emotional distress of the elderly or adult with a disability.

c. **Financial or Property Exploitation** - Illegal or improper use of an elderly or adult with a disability's money, property or other resources for monetary or personal benefit, profit or gain. This includes, but is not limited to, theft, misappropriation, concealment, misuse or fraudulent deprivation of money or property belonging to the elderly or adult with a disability.

d. **Neglect** - The failure of a reasonable caregiver to provide for the physical, mental or emotional health and well-being of the elderly or adult with a disability and includes, but is not limited to:

   1 Failure to assist or provide personal hygiene.

2. Failure to provide adequate food, water, clothing or shelter.

3. Failure to provide medical care for the physical and mental health of the individual. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

4. Failure to protect an individual from health, safety hazards, or physical harm.

e. **Physical Abuse** - The willful infliction of or omission which results in physical harm. It includes, but is not limited to, cruel punishment resulting in physical harm or pain or mental anguish, such as direct beatings, slapping, kicking, biting, choking, burning, sexual assault or molestation, or unreasonable physical restraint or confinement resulting in physical injury.

f. **Physical Harm** - Means bodily pain, injury, impairment or disease.

g. **Self-Neglect** - Is the behavior of an elderly or adult with a disability that threatens his/her own safety. Self-neglect generally manifests itself when an elderly or adult with a disability refuses to provide him/herself with adequate food, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions. The definition of self-neglect excludes a situation in which a mentally competent elderly or adult with a disability, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice.

h. **Sexual Abuse** – Means any form of non-consensual sexual contact, including but not limited to, unwanted or inappropriate sexual gratification, touching, rape, sodomy, sexual coercion, sexually explicit photographing, sexual harassment, involuntary exposure to sexually explicit material or language, and as defined in the penal code of Guam.

Reporting Requirements

Individuals who are required to report include:

a. Any persons who, in the course of their employment, occupation or professional practice come into contact with elderly or adults with disabilities, has actual knowledge or reasonable cause to believe that an elderly or adult with a disability is suffering from or has died as a result of abuse, shall immediately make a verbal report of such information or cause a report to be made to the Bureau of Adult Protective Services or its authorized agency and shall, within 48 hours, make a written report to the Bureau or its authorized agency. If a verbal report is made on a Friday, a written report will be made by the next workday.

b. Persons required to report abuse under this Law include, but are not limited to physicians, medical interns, medical examiners, nurses, chiropractors, hospital personnel engaged in the admission, examination, care or treatment of persons, social workers, employees of nursing homes, senior citizen centers and adult day care facilities, police officers, probation officers, employees of homemaker and home health service agencies, emergency medical service (EMS) providers, non-emergency medical transport providers, banking or financial institution personnel, pension providers, and practicum students in the field of health and human services.

c. In addition to persons required to report, any other person may make such report to the Bureau of Adult Protective Services if any such person has reasonable cause to believe that an elderly or adult who has a disability is suffering from or has died as a result of abuse.

Reports shall include:

a. The name of the person making the report and where he or she can be reached. However, reports of abuse may be made anonymously. Any person who in good faith makes a report under this article or testifies in any administrative or judicial proceeding related to the report is immune from civil or criminal liability for reporting or testifying. The identity of the person making the report shall be confidential.

b. The name, address and approximate age of the elderly or adult with a disability.

c. Information regarding the nature and extent of the abuse, the name of the person's caretaker, if known, and any medical treatment being received or immediately required, if known.

d. The name of the person or persons responsible for causing the suspected abuse.

e. The source of the report.

f. Any other information which may assist in the investigation of the suspected abuse.

Failure to Report

Any person who is required to report a case of suspected abuse who fails to report shall be liable for a fine of not more than $500, except that for a second or subsequent offense, such person shall be guilty of a misdemeanor.

All individuals must strictly adhere to the Adult Protective Services Mandates. In addition to the APS mandates, the following information is provided:

a. Any individual who suspects any category of abuse will immediately contact the Bureau of Adult Protective Services at 735-7421 or 7415. This contact number is valid Monday through Friday, 8:00 a.m. to 5:00 p.m. with the exception of federally or locally authorized holidays.

b. After 5:00 p.m. or during the weekend or on federally or locally authorized holidays contact the Guma Serenidad Crisis Intervention Hotline at 632-8853.

REMEMBER THE RULE OF THUMB:

WHEN IN DOUBT.....REPORT!

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF SENIOR CITIZENS

PROCEDURES FOR REPORTING ABUSE OF THE ELDERLY OR ADULTS WITH DISABILITIES, PUBLIC LAW 31-278

By signing below I acknowledge that I received, read and understand the **PROCEDURES FOR REPORTING ABUSE OF THE ELDERLY OR ADULTS WITH DISABILITIES, PUBLIC LAW 31-278.**

Print Name	Position Title
Signature	Date

aps ADULT PROTECTIVE SERVICES