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| REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT |
| Michigan Department of Health and Human Services |
| Was Complaint Phoned to MDHHS? |
| [ ]  | Yes | [ ]  | No | ⏵ | If yes, Intake ID # |       | ⏵ | If no, contact Centralized Intake (855-444-3911) immediately |
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| **INSTRUCTIONS:** REPORTING PERSON: Complete items 1-19 (20-28 should be completed by medical personnel, if applicable). Send to Centralized Intake at the address listed on page 2. | 1. Date |
|       |
| 2. List of Child(ren) Suspected of Being Abused or Neglected. **To insert additional rows, tab at the end of last row to create a new row.** |
| NAME | BIRTH DATE | SOCIAL SECURITY # | SEX | RACE |

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| 3. Mother’s Name |  |  |  |  |
|       |       |       |       |       |
| 4. Father’s Name |  |  |  |  |
|       |       |       |       |       |
| 5. Child(ren)’s Address (No. & Street) | 6. City | 7. County | 8. Phone No. |
|       |       |       |       |
| 9. Name of Alleged Perpetrator of Abuse or Neglect | 10. Relationship to Child(ren) |
|       |       |
| 11. Person(s) The Child(ren) Living With When Abuse/Neglect Occurred | 12. Address, City & Zip Code Where Abuse/Neglect Occurred |
|       |       |
| 13. Describe Injury or Conditions and Reason for Suspicion of Abuse or Neglect  |
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| 14. Source of Complaint (Add reporter code below) |  |
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| 01 Private Physician/Physician’s Assistant | 11 School Nurse | 42 MDHHS Facility Social Worker |
| 02 Hosp/Clinic Physician/Physician’s Assistant | 12 Teacher | 43 DMH Facility Social Worker |
| 03 Coroner/Medical Examiner | 13 School Administrator | 44 Other Public Social Worker |
| 04 Dentist/Register Dental Hygienist | 14 School Counselor | 45 Private Agency Social Worker |
| 05 Audiologist | 21 Law Enforcement | 46 Court Social Worker |
| 06 Nurse (Not School) | 22 Domestic Violence Providers | 47 Other Social Worker |
| 07 Paramedic/EMT | 23 Friend of the Court | 48 FIS/ES Worker/Supervisor |
| 08 Psychologist | 25 Clergy | 49 Social Services Specialist/Manager (CPS, FC, etc.) |
| 09 Marriage/Family Therapist | 31 Child Care Provider | 56 Court Personnel |
| 10 Licensed Counselor | 41 Hospital/Clinic Social Worker |  |
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| 15. Reporting Person’s Name | Report Code (see above) | 15a. Name of Reporting Organization (school, hospital, etc.) |
|       |    |       |
| 15b. Address (No. & Street) | 15c. City | 15d. State | 15e. Zip Code | 15f. Phone Number |
|       |       |    |       |       |
| 16. Reporting Person’s Name | Report Code (see above) | 16a. Name of Reporting Organization (school, hospital, etc.) |
|       |    |       |
| 16b. Address (No. & Street) | 16c. City | 16d. State | 16e. Zip Code | 16f. Phone Number |
|       |       |    |       |       |
| 17. Reporting Person’s Name | Report Code (see above) | 17a. Name of Reporting Organization (school, hospital, etc.) |
|       |    |       |
| 17b. Address (No. & Street) | 17c. City | 17d. State | 17e. Zip Code | 17f. Phone Number |
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| 18. Reporting Person’s Name | Report Code (see above) | 18a. Name of Reporting Organization (school, hospital, etc.) |
|       |    |       |
| 18b. Address (No. & Street) | 18c. City | 18d. State | 18e. Zip Code | 18f. Phone Number |
|       |       |    |       |       |
| 19. Reporting Person’s Name | Report Code (see above) | 19a. Name of Reporting Organization (school, hospital, etc.) |
|       |    |       |
| 19b. Address (No. & Street) | 19c. City | 19d. State | 19e. Zip Code | 19f. Phone Number |
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| TO BE COMPLETED BY MEDICAL PERSONNEL WHEN PHYSICAL EXAMINATION HAS BEEN DONE |
| 20. Summary Report and Conclusions of Physical Examination (Attach Medical Documentation) |
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| 21. Laboratory Report | 22. X-Ray |
|       |       |
| 23. Other (specify) | 24. History or Physical Signs of Previous Abuse/Neglect |
|       | [ ]  | YES | [ ]  | NO |
| 25. Prior Hospitalization or Medical Examination for This Child |
| **DATES** | **PLACES** |
|       |       |
|       |       |
| 26. Physician’s Signature | 27. Date | 28. Hospital (if applicable) |
|  |       |       |
| The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. | AUTHORITY: P.A. 238 of 1975.COMPLETION: Mandatory.PENALTY: None. |
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| INSTRUCTIONS |
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| GENERAL INFORMATION:This form is to be completed as the written follow-up to the oral report (as required in Sec. 3 (1) of 1975 PA 238, as amended) and mailed to Centralized Intake for Abuse & Neglect. Indicate if this report was phoned into MDHHS as a report of suspected CA/N. If so, indicate the Log # (if known). The reporting person is to fill out as completely as possible items 1-19. Only medical personnel should complete items 20-28.Mail this form to:Centralized Intake for Abuse & Neglect5321 28th Street Court, SEGrand Rapids, MI 49546ORFax this form to 616-977-8900 or 616-977-8050 or 616-977-1158 or 616-977-1154 OR email this form to MDHHS-CPS-CIGroup@michigan.gov1. Date – Enter the date the form is being completed.
2. List child(ren) suspected of being abused or neglected – Enter available information for the child(ren) believed to be abused or neglected. Indicate if child has a disability that may need accommodation.
3. Mother’s name – Enter mother’s name (or mother substitute) and other available information. Indicate if mother has a disability that may need accommodation.
4. Father’s name – Enter father’s name (or father substitute) and other available information. Indicate if father has a disability that may need accommodation.

5.-7. Child(ren)’s address – Enter the address of the child(ren).1. Phone Number – Enter phone number of the household where child(ren) resides.
2. Name of alleged perpetrator of abuse or neglect – Indicate person(s) suspected or presumed to be responsible for the alleged abuse or neglect.
3. Relationship to child(ren) – Indicate the relationship to the child(ren) of the alleged perpetrator of neglect or abuse, e.g., parent, grandparent, babysitter.
4. Person(s) child(ren) living with when abuse/neglect occurred – Enter name(s). Indicate if individuals have a disability that may need accommodation.
5. Address where abuse / neglect occurred.
6. Describe injury or conditions and reason of suspicion of abuse or neglect – Indicate the basis for making a report and the information available about the abuse or neglect.
7. Source of complaint – Check appropriate box noting professional group or appropriate category.

**Note:** If abuse or neglect is suspected in a hospital, also check hospital.15.-19 - Reporting person’s name - Enter the name and address of person(s) reporting this matter. |