

Iowa Department on Aging – EAPA Service Form

Complete this form for individuals referred to Elder Abuse Prevention and Awareness (EAPA) Program only.

Date Completed: _____

Consumer LAST NAME: _____ **FIRST:** _____ **MI:** _____

REFERRAL INFORMATION

Referral Date: ____ / ____ / ____

Referral Source:

- | | | |
|--|---|--|
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Family | <input type="checkbox"/> Options Counselor |
| <input type="checkbox"/> Community Provider | <input type="checkbox"/> Family Caregiver Program | <input type="checkbox"/> Self |
| <input type="checkbox"/> Dept. of Human Services | <input type="checkbox"/> Friend | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dept. of Inspection & Appeals | <input type="checkbox"/> Law Enforcement | |
| <input type="checkbox"/> Elder Rights Specialist | <input type="checkbox"/> LifeLong Links | |

CONSULTATION INFORMATION

Consult Date: ____ / ____ / ____ **Consult Length (Minutes)** _____

Consult Outcome:

- | | | |
|--|---|---|
| <input type="checkbox"/> EAPA Assessment & Intervention | <input type="checkbox"/> Consumer will Self-Advocate | <input type="checkbox"/> Refused Assistance |
| <input type="checkbox"/> Refer: Case Management | <input type="checkbox"/> Refer: Family Caregiver Program | <input type="checkbox"/> Refer: Options Counselor |
| <input type="checkbox"/> Refer: Dept. of Human Services | <input type="checkbox"/> Refer: Dept. of Inspection & Appeals | |
| <input type="checkbox"/> Refer: Community Provider | <input type="checkbox"/> Refer: Law Enforcement | <input type="checkbox"/> Refer: OSDM |
| <input type="checkbox"/> Refer: Legal Services / Hotline | <input type="checkbox"/> Other | |

ASSESSMENT & INTERVENTION INFORMATION

Admit Priority: 1 2 3 **Assessment Date:** ____ / ____ / ____ **Type:** Single Joint

Intervention Type (May pick more than one):

- | | | | |
|---|--|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Financial Exploitation | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Other |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Psychological Abuse | <input type="checkbox"/> Self Neglect | |

Discharge Date: ____ / ____ / ____

Discharge Reason:

- Services No Longer Needed
- Client Moved out of Area
- Client Moved into Facility
- Termination Requested
- Client Unwilling or Unable to Meet Terms
- Refused to Provide Information
- Risk of Harm to Provider
- Other

Discharge To:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Assisted Living Program | <input type="checkbox"/> OSDM |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> LTC Facility |
| <input type="checkbox"/> Community Provider | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family | <input type="checkbox"/> None |
| <input type="checkbox"/> Family Caregiver Program | |
| <input type="checkbox"/> Friend | |
| <input type="checkbox"/> Legal Services / Hotline | |
| <input type="checkbox"/> Options Counselor | |