REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT

Michigan Department of Human Services

Was complaint phoned to DHS?

☐ Yes ☐ No ▶ If yes, Log # _____ ▶ If no, contact Centralized Intake (855-444-3911) immediately

INSTRUCTIONS: REPORTING PERSON: Complete items 1-19 (20-28 should be completed by medical personnel, if applicable). Send to Centralized Intake at the address list on page 2.

1. Date

2. List of child(ren) suspected of being abused or neglected (Attach additional sheets if necessary)

NAME	BIRTH DATE	SOCIAL SECURITY #	SEX	RACE
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

_____

_____

14. Source of Complaint (Add reporter code below)

01 Private Physician/Physician's Assistant
02 Hosp/Clinic Physician/Physician's Assistant
03 Coroner/Medical Examiner
04 Dentist/Register Dental Hygienist
05 Audiologist
06 Nurse (Not School)
07 Paramedic/EMT
08 Psychologist
09 Marriage/Family Therapist
10 Licensed Counselor
11 School Nurse
12 Teacher
13 School Administrator
14 School Counselor
21 Law Enforcement
22 Domestic Violence Providers
23 Friend of the Court
25 Clergy
31 Child Care Provider
41 Hospital/Clinic Social Worker
42 DHS Facility Social Worker
43 DMH Facility Social Worker
44 Other Public Social Worker
45 Private Agency Social Worker
46 Court Social Worker
47 Other Social Worker
48 FIS/ES Worker/Supervisor
49 Social Services Specialist/Manager (CPS, FC, etc.)
56 Court Personnel

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 No.
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 No.
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 No.
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 No.
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 No.

TO BE COMPLETED BY MEDICAL PERSONNEL WHEN PHYSICAL EXAMINATION HAS BEEN DONE

20. Summary report and conclusions of physical examination (Attach Medical Documentation)		
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)
Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.	AUTHORITY: P.A. 238 of 1975. COMPLETION: Mandatory. PENALTY: None.	

INSTRUCTIONS

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 DHS 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 & Neglect
5321 28th Street Court S.E.
Grand Rapids, MI 49546

OR

Fax this form to 616-977-8900 or 616-977-8050 or 616-977-1158 or 616-977-1154
OR
email this form to DHS-CPS-CIGroup@michigan.gov

1. 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).

8. Phone – Enter phone number of the household where child(ren) resides.
9. Name of alleged perpetrator of abuse or neglect – Indicate person(s) suspected or presumed to be responsible for the alleged abuse or neglect.
10. Relationship to child(ren) – Indicate the relationship to the child(ren) of the alleged perpetrator of neglect or abuse, e.g., parent, grandparent, babysitter.
11. Person(s) child(ren) living with when abuse/neglect occurred – Enter name(s). Indicate if individuals have a disability that may need accommodation.
12. Address where abuse / neglect occurred.
13. 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.
14. 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.

DHS Facility – Refers to any group home, shelter home, halfway house or institution operated by the Department of Human Services.

DCH Facility – Refers to any institution or facility operated by the Department of Community Health.

15.-19 - Reporting person's name - Enter the name and address of person(s) reporting this matter.