

# REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT

## Michigan Department of Human Services

Was complaint phoned to DHS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <span style="margin-left: 20px;">▶ If yes, Log # <u>0123456</u></span> <span style="margin-left: 20px;">▶ If no, contact Centralized Intake (855-444-3911) immediately</span>				
<b>INSTRUCTIONS:</b> 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 <b>02/25/xxxx</b>
2. List of child(ren) suspected of being abused or neglected (Attach additional sheets if necessary)				
<b>NAME</b>	<b>BIRTH DATE</b>	<b>SOCIAL SECURITY #</b>	<b>SEX</b>	<b>RACE</b>
<b>Amanda James</b>	<b>07/28/xxxx</b>	<b>Unknown</b>	<b>Female</b>	<b>Caucasian</b>
<b>Melissa James</b>	<b>03/25/xxxx</b>	<b>Unknown</b>	<b>Female</b>	<b>AA/C</b>
3. Mother's name <b>Sheryl James</b>				
4. Father's name <b>Mark Anderson/Steven Miller</b>				
5. Child(ren)'s address (No. & Street) <b>801 S. Waverly Rd</b>				
6. City <b>Lansing</b>				
7. County <b>Ingham</b>				
8. Phone No. <b>517-555-1908</b>				
9. Name of alleged perpetrator of abuse or neglect <b>Sheryl James and Steven Miller</b>				
10. Relationship to child(ren) <b>Mother of both children, father of child 2</b>				
11. Person(s) the child(ren) living with when abuse/neglect occurred <b>Sheryl James and Steven Miller</b>				
12. Address, City & Zip Code where abuse/neglect occurred <b>1801 S. Waverly, Lansing, 48917</b>				
13. Describe injury or conditions and reason for suspicion of abuse or neglect <b>Amanda reports that she and her 3 year old sister were left home alone last night 7-9 pm.</b> <b>Amanda reports that this happens often, and that when mom and mom's boyfriend leave, she never knows when they will come back.</b>				
14. Source of Complaint (Add reporter code below)				
01 Private Physician/Physician's Assistant      13 School Administrator      45 Private Agency Social Worker 02 Hosp/Clinic Physician/Physician's Assistant      14 School Counselor      46 Court Social Worker 03 Coroner/Medical Examiner      21 Law Enforcement      47 Other Social Worker 04 Dentist/Register Dental Hygienist      22 Domestic Violence Providers      48 FIS/ES Worker/Supervisor 05 Audiologist      23 Friend of the Court      49 Social Services Specialist/Manager (CPS, FC, etc.) 06 Nurse (Not School)      25 Clergy      51 Hospital/Clinic Personnel 07 Paramedic/EMT      31 Child Care Provider      52 DHS Facility Personnel 08 Psychologist      41 Hospital/Clinic Social Worker      53 DMH Facility Personnel 09 Marriage/Family Therapist      42 DHS Facility Social Worker      54 Other Public Social Agency Personnel 10 Licensed Counselor      43 DMH Facility Social Worker      55 Private Social Agency Personnel 11 School Nurse      44 Other Public Social Worker      56 Court Personnel 12 Teacher				
15. Reporting person's name <b>Casey Hall</b>		Report Code (see above) <b>12</b>	15a. Name of reporting organization (school, hospital, etc.) <b>Colt Elementary School</b>	
15b. Address (No. & Street) <b>4344 W. Michigan Ave.</b>		15c. City <b>Lansing</b>	15d. State <b>MI</b>	15e. Zip Code <b>48917</b>
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
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
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
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

**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 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. Prior hospitalization or medical examination for this child		
DATES	PLACES	
N/A		
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 28<sup>th</sup> Street Court S.E.  
Grand Rapids, MI 49546

OR

Fax this form to 616-977-1154 or 616-977-1158  
Or email this form to [DHS-CPS-CIGroup@michigan.gov](mailto: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.

Training