DAVID Y. IGE GOVERNOR

Name/Agency/Title:



RACHAEL WONG, DrPH DIRECTOR

PANKAJ BHANOT DEPUTY DIRECTOR

STATE OF HAWAII DEPARTMENT OF HUMAN SERVICES Child Welfare Services Intake Unit 420 Waiakamilo Road, Suite 300A Honolulu, HI 96817-4941

CONFIDENTIAL

MANDATED REPORTER CHECKLIST FOR SUSPECTED CHILD ABUSE AND NEGLECT

Oahu Reporting Line: (808) 832-5300 Toll Free Neighbor Islands: 1-800-494-3991 Oahu FAX: (808) 832-5292 Toll Free Neighbor Islands FAX: 1-800-399-1614

To file a report of Child Abuse and Neglect, please:

- 1. Review available records and fill out the checklist as completely as possible using <u>Y</u> for yes, <u>N</u> for no, or as specified. Leave blank if unknown, unless otherwise indicated.
- 2. Immediately call the **CWS Intake Reporting Line at (808) 832-5300 or toll free for neighbor islands at 1-800-494-3991** to report your findings. Be sure to obtain the name of the intake social worker to document receipt and disposition of your referral.
- 3. FAX or Mail this document with comments to CWS immediately <u>after</u> verbally reporting to the intake worker. Doing so fulfills your statutory obligation under Chapter 350-1.1(c), Hawaii Revised Statutes, which requires a report in writing as well as the oral report.

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Address:	Telephone:
MANDATED REPORTER ORAL REPORT	CONTACT WITH CWS AND/OR POLICE
Name of CWS Intake Social Worker	Date/Time of Report
Name of Police Officer/Badge #	Date/Time of Report/Police Report #
May CWS share your identity with the county police, or cor	ntract VCM or FSS provider for follow up? Yes No

MANDATED REPORTER INFORMATION

	P.	ARENT/CAR	EGIVER INFORMA	ATION: (Circl	le where applic	cable)	
FATHER	GUARDIAN	OTHER	ALLEGED	MOTHER	GUARDIAN	OTHER	ALLEGED
			MALTREATOR				MALTREATOR
Name:			DOB/Age	Name:			DOB/Age
Address or Directions:			Address or Directions:				
Employment/Phone			Employment/Phone				
Telephone: Military/Branch		nch of Service	Telephone:		Military/	Branch of Service	

OTHER ALLEGED MALTREATER/S				
Name:	DOB/Age	Name:	DOB/Age	
Address or Directions:		Address or Directions:		
Telephone:		Telephone:		
Relationship to victim:		Relationship to victim:		

OTHER FAMILY/HOUSEHOLD MEMBERS/SIGNIFICANT KIN						
Name DOB/Age Relationship to Victim						
1.						
2.						
3.						
4.						

CHILD/VICTIM INFORMATION					
Name DOB/ Victim? School/Grade/SPED Home Address/or Directions Age Y/N					
1.					
2.					
3.					
4.					

FACTORS

A. TYPE OF HARM:

7. 111 E O1 10 u cm:	
Physical abuse	Threatened physical abuse
Sexual abuse	Threatened sexual abuse
Physical neglect	Threatened physical neglect
Psychological/emotional abuse	Threatened psychological harm

B. EVIDENCE OF HARM:

а	Substantial/multiple skin bruising/Internal Bleeding	j	Extreme pain
b	Injury causing substantial bleeding	k	Extreme mental distress
С	Malnutrition	1	Gross degradation (extreme humiliation)
d	Failure to thrive	М	Death
е	Burns	n	Physical or medical evidence of sexual abuse
f	Poisoning	0	Injury to the psychological capacity/impairment in child's functioning
g	Any fracture	р	Failure to provide adequate care or supervision
h	Subdural hematoma (per medical diagnosis)	q	Intentional Drugging
i	Soft tissue swelling	r	Other:

C. HISTORY, FREQUENCY, DURATION, INTENSITY OF HARM, if known by reporter:

-	, , , , , ,	,
	Single incident, no history, no previous incidents	Occurs repeatedly, several times/year, escalating
	Infrequent incidents, no escalation, short duration	Chronic and serious, ongoing pattern of harm

D. BEHAVIORAL: (Has the **child** demonstrated any of the following behaviors?)

а	Danger to others: Assaults/aggression	е	Status Offenses or Law Violation
b	Danger to self/self destructive/suicidal	f	Education/Academic Difficulties
С	Mental Health Issues, Withdrawal or depression	g	Fear of caretaker/returning home/being harmed
			again
d	Inappropriate sexual knowledge/seductive	i	Other: Specify

E. SERVICES/TREATMENT HISTORY:

Mental Health /Psychiatric Services

Has the family participated or been offered/referred to any service or treatment prior to the report of harm such as: (Yes, No, Unknown, or Declined, Identified as a need) If known, identify service provider and contact information. Parenting classes Medical/Health Services а g b Family violence services (domestic/family h **Public Health Nursing** abuse) i Substance abuse counseling/treatment С Educational programs Inpatient_ Outpatient Anger management d Individual counseling or therapy Intensive home based (outreach, home visit) k CWS involvement (Hawaii or other) е

Other, Specify:

F. SUPPORT SYSTEM:

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Support system available to the child and family, willing and able to assist. If known, identify pers and contact information.				g and able to assist. If known, identify person(s)
а		Parents	F	Friends
b		Maternal grandparents	G	Church members
С		Paternal grandparents	h	Community groups
d		Siblings	i	Service providers
е		Other relatives	j	Other: specify below

G. NARRATIVE INFORMATION:

Please provide a brief narrative description of the incident(s) and what action you believe needs to be taken. If known, include dates and location. (Use additional sheets as needed)

THANK YOU FOR YOUR ASSISTANCE.