# Office of Client Advocacy

**Intake Referral**

Anonymous

**Your Information**

First name Middle name Last name

Email Telephone Relationship to service recipient

# Who is this Regarding? (Service Recipient)

First name Middle name Last name

Date of birth Age Gender Race

Social Security number Phone number

Address City State Zip code

OJA

OHS

Parental

Tribal

Services received (check all that apply):  ADvantage Waiver

Advantage Waiver

Developmental disability services

Hissom Class

State Plan Personal Care

 Developmental disability services  Hissom class

 State Plan Personal Care

Custody status:  OJA

 OHS

 Parental  Tribal

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service**  **recipient's:** | **Name** | **Address** | **Email** | **Telephone** |
| Provider agency |  |  |  |  |
| Guardian |  |  |  |  |
| Next of kin |  |  |  |  |
| Power of attorney |  |  |  |  |

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|  |  |  |  |  |
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| **Service**  **recipient's:** | **Name** | **Address** | **Email** | **Telephone** |
| Provider agency |  |  |  |  |
| Guardian |  |  |  |  |
| Next of kin |  |  |  |  |
| Power of attorney |  |  |  |  |

**Summary of Allegation or Reason for Requesting Assistance (add pages as needed)**

**If this is a request for Special Advocacy, you do not need to advance further. However, if there are allegation of abuse, neglect, or exploitation, please fill out remaining sections.**

**Allegation Details**

Who initially disclosed the allegation?

First name Middle name Last name

Telephone Relationship to service recipient Current location of service recipient

Current condition of service recipient

Service recipient's level of supervision

Briefly describe injuries, if any.

Were photos taken? Yes No Unknown

Any witnesses? Yes No Unknown

Law enforcement involvement? Yes No Unknown

Exact date of incident Exact time of incident Approximate date/time of incident

Exact location of incident County where incident occurred

**Accused Caretaker(s)**

If there are multiple accused caretakers, list the one causing the greatest injury or risk of injury first.

First name Middle name Last name

Date of birth Gender Email Telephone

Address City State Zip code

Community services worker Medicaid personal care assistant Licensed health professional

Shift Job title Caretaker status (ie. suspended)

First name Middle name Last name

Date of birth Gender Email Telephone

Address City State Zip code

Community services worker Medicaid personal care assistant  Licensed health professional

Shift Job title Caretaker status (ie. suspended)

**Facility/Provider Information**

Facility/provider name

Community Services Provider Medicaid Personal Care Services Provider

Contact person Telephone

NOTE: If any of the accused caretakers or alleged victims are no longer at the facility/provider agency, please record how to locate them in the "Other Information" section below.

**Witnesses to the Alleged Incident**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Involvement** | **Relationship to victim** | **Contact information** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Other Information**

**Routing**

Please submit completed form to OCA at [oca.intake@health.ok.gov.](mailto:oca.intake@health.ok.gov)

**Office Client Advocacy (OCA) Use Only**

Intake number Intake date Intake status Intake staff

Priority case