REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT

Michigan Department of Health and Human Services

Was Complaint Phoned to MDHHS?

☐ Yes ☐ No ▶ If yes, Intake ID # _____ ▶ 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 listed on page 2.

1. Date

2. List of Child(ren) Suspected of Being Abused or Neglected. **To insert additional rows, tab at the end of last row to create a new row.**

NAME	BIRTH DATE	SOCIAL SECURITY #	SEX	RACE
"Click Here and Type"				

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

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 Number
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 Number
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 Number
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 Number
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 Number

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)

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	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 MDHHS 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, SE
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 MDHHS-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 Number – 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.

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