OKLAHOMA State Department of Health

Office of Client Advocacy
Intake Referral

Your Information

☐ Anonymous

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

Services received (check all that apply):

- ☐ ADvantage Waiver
- ☐ 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				

First name | Middle name | Last name

Date of birth | Age | Gender | Race

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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.

Office Client Advocacy (OCA) Use Only

Intake number

Intake date

Intake status

☐ Priority case

Intake staff