

Jefferson County Protective Placement Questionnaire

This questionnaire has been developed to assist Jefferson County in processing protective placements as quickly and efficiently as possible. Please provide as much information as you can in responding to each question. Attach additional documents, such as medical or psychological reports, and refer to these in appropriate answer section(s). If an area is not applicable, please indicate that.

If a comprehensive evaluation has already been or will be filed by the petitioner, please provide the Jefferson County Human Services Department, Adult Protective Services with a copy, and disregard the remainder of this questionnaire.

THIS FORM MUST BE SUBMITTED TO THE ADULT PROTECTIVE SERVICES UNIT AT LEAST TEN DAYS PRIOR TO THE HEARING DATE. FAILURE TO TIMELY PROVIDE THE REQUESTED INFORMATION MAY DELAY PLACEMENT.

**Please submit to: Adult Protective Services Unit
Jefferson County Human Services Department
1541 Annex Road
Jefferson, WI 53549**

I. Identifying Information for Person in Need
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Name: _____ **Date of Birth:** _____

Address: _____ **Court Case Number:** _____

Current Placement (if different than above): _____

II. Person or Agency Currently Providing Services (If Any)

Name: _____

Address: _____

III. Please describe any professional treatment or services (medical, therapies, psychological, etc.) If any, that have been provided to the individual in connection with the problem(s) creating the need for protective placement, as well as service frequency.

****indicate sources of information-Medical Practitioners, other care providers, etc.**

****Also indicate service frequency, if appropriate.**

IV. Evaluation and Review Information

A. Describe current medical status (including medications): _____

B. Describe current psychological state: _____

C. Describe current social status (any social/family history, daily living routines): _____

D. Describe any educational/vocational or current job placement/history: _____

V. Placement Information

A. Please indicate, if known, the type of placement needed (Hospital, Adult Family Home (AFH), Community Based Residential Facility (CBRF), Skilled Nursing Facility (SNF), or an Intermediate Care Facility for Individuals with Intellectual Disabilities):

B. Please indicate what services you believe will be needed (medical, vocational, daily living skills, rehab stay, etc.): _____

VI. Additional Comments/Special Needs:

Submitted By: _____

Address: _____

Telephone: _____

Fax: _____

Email: _____

Please submit to:

**Adult Protective Services Unit
Jefferson County Human Services Department
N1541 Annex Road
Jefferson, WI 53549**

At least 10 days prior to the hearing date.