

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

Report of Suspected Child Abuse or Neglect

Child Protective Services Central Intake: 1-866-820-5437

Facility Name: _____ PV#: _____
Reporter Name: _____ Date of Report: _____
Name of Centralized Intake Worker: _____

Name of Child: _____ Birth Date: _____
Child's Address: _____

Parent/Guardian Name: _____
Parent/Guardian Address: _____

Person(s) Suspected of Abuse/Neglect: _____ Relationship: _____
Address: _____

Type of suspected abuse being reported:

- Physical Injury
- Physical Neglect
- Other (specify): _____
- Sexual Abuse
- Emotional Neglect / Abuse

What is the nature and extent of the abuse/neglect? _____

What are the circumstances leading to the suspicion of abuse/neglect? _____

Are there any previous reports of abuse/neglect for this child/family? _____

Previous action taken? _____

REPORTER SIGNATURE

DATE

SUPERVISOR SIGNATURE (if applicable)

DATE