**TO BE RETURNED TO:**

**Office use only:**

Date Received:

Probate File #:

Guardian Appt &Type:

Conservator Appt & Type:



Connections Human Services

852.S. Hooper St. Suite 6

Caro Mi 48723

Phone 989 672 1268

Fax 989 672 1278

EMAIL CONNECTIONSHUMANSERVICES@GMAIL.COM

**REFERRAL FOR PROFESSIONAL GUARDIANSHIP SERVICES**

Please supply as much information as you have available. Completion of this form does not guarantee acceptance into the guardianship program. Acceptance into the guardianship program is based on whether the guardianship program is appropriate for the individual and whether there is capacity in our program to address the needs of additional clients.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. REFERRING SOURCE CONTACT INFORMATION | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | Date Submitted: | | | | | | | | |
| Agency: | | | | | | | | E-mail: | | | | | | | | |
| Telephone: | | | | | | | | Fax: | | | | | | | | |
| Relationship to proposed ward: | | | | | | | | | | | | | | | | |
| Referral being made for (please check all that apply): Representative Payee Services  Guardian Conservator Developmentally Disabled | | | | | | | | | | | | | | | | |
| How did you hear about our services? | | | | | | | | | | | | | | | | |
| 1. GENERAL INFORMATION – PROPOSED WARD | | | | | | | | | | | | | | | | |
| Name (last, first, middle): | | | | | | | | | | | | | | | | |
| Other names used: | | | | | | | | | | | | | | | | |
| Date of Birth: | | | | | Age: | | | Social Security # | | | | | | | | |
| Gender Identity: Male Female Unknown | | | | | | | | | Language: | | | | | | | |
| Religion: | | | | | | | | Preferred Church: | | | | | | | | |
| Father’s Name: | | | | | | | | Mother’s Name: | | | | | | | | |
| Place of Birth: | | | | | | | | Veteran:  Yes No Unknown | | | | | | | | |
| Branch of Service: | | | | | | | | VA # | | | | | | | | |
| Marital Status: Single/Never married Married Divorced Widowed Separated  Unknown | | | | | | | | | | | | | | | | |
| If divorced - spouse name, date and place of divorce: | | | | | | | | | | | | | | | | |
| If widowed - spouse name, date and place of death: | | | | | | | | | | | | | | | | |
| 1. CURRENT LIVING SITUATION – PROPOSED WARD | | | | | | | | | | | | | | | | |
| Does proposed ward currently live alone? Yes No | | | | | | | | | | | | | | | | |
| Home address: | | | | | | | | | | | | | | | | |
| Current location of proposed ward, if different than home address: | | | | | | | | | | | | | | | | |
| Date admitted to current facility: | | | | | | | | | | | | | | | | |
| Date(s) of previous admissions to current facility: | | | | | | | | | | | | | | | | |
| Discharge Plan: Skilled Nursing Residential Care Facility Independent Living/Home  Other: | | | | | | | | | | | | | | | | |
| Facilities where referrals have been made: | | | | | | | | | | | | | | | | |
| Anticipated discharge date: | | | | | | | | | | | | | | | | |
| 1. LEGAL STATUS OF PROPOSED WARD | | | | | | | | | | | | | | | | |
| Does any person or institution currently have legal guardianship, power of attorney, custody and/or control of proposed ward? Yes No  If yes, who and status: | | | | | | | | | | | | | | | | |
| 1. NEED FOR GUARDIANSHIP | | | | | | | | | | | | | | | | |
| In what way will a guardianship benefit the proposed ward? What **unmet needs** exist that cannot be addressed by another agency or service? | | | | | | | | | | | | | | | | |
| Briefly describe the chronology of recent events that resulted in the need to refer this individual for guardianship: | | | | | | | | | | | | | | | | |
| If exploitation, abuse, or neglect is suspected, has a police report been filed? Yes No  If yes, please attach a copy and provide case #: | | | | | | | | | | | | | | | | |
| Does proposed ward have a private attorney? Yes No  If yes, please provide name and full contact information: | | | | | | | | | | | | | | | | |
| 1. ALTERNATIVES TO GUARDIANSHIP Guardianship is a last resort. Please check below alternatives to guardianship that have already been used and include dates of service and outcomes. | | | | | | | | | | | | | | | | |
|  | Assistance from family and/or friends | | | | | | | | | | | | | | | |
|  | Case Management | | | | | | | | | | | | | | | |
|  | DHS Services | | | | | | | | | | | | | | | |
|  | Mental Health Services | | | | | | | | | | | | | | | |
|  | Day Program | | | | | | | | | | | | | | | |
|  | Homemaker Services | | | | | | | | | | | | | | | |
|  | Meals on Wheels | | | | | | | | | | | | | | | |
|  | Representative Payee and/or money management services | | | | | | | | | | | | | | | |
|  | Senior Services | | | | | | | | | | | | | | | |
|  | VA Services | | | | | | | | | | | | | | | |
|  | Other | | | | | | | | | | | | | | | |
|  | Other | | | | | | | | | | | | | | | |
|  | Other | | | | | | | | | | | | | | | |
| Other agencies or professionals/social workers involved or providing services (include phone number or e-mail for each one listed): | | | | | | | | | | | | | | | | |
| 1. MEDICAL & MENTAL HEALTH PROVIDERS AND INFORMATION | | | | | | | | | | | | | | | | |
| **Type** | | | | **Name and address** | | | | | | | | | | **Telephone** | | |
| Primary Care Physician | | | |  | | | | | | | | | |  | | |
| Dentist | | | |  | | | | | | | | | |  | | |
| Eye Care | | | |  | | | | | | | | | |  | | |
| Mental Health | | | |  | | | | | | | | | |  | | |
|  | | | |  | | | | | | | | | |  | | |
|  | | | |  | | | | | | | | | |  | | |
| Is there a history of, or any recent, violent threats or actions noted? Yes No  If yes, describe: | | | | | | | | | | | | | | | | |
| What is current mental status of proposed ward? Are there any psychiatric concerns? | | | | | | | | | | | | | | | | |
| What is drug/alcohol history of proposed ward? | | | | | | | | | | | | | | | | |
| 1. HEALTH INSURANCE | | | | | | | | | | | | | | | | |
| **Type** | | | **Name of Company**  **Policy and/or Member #** | | | | | | | **Effective Date of Coverage** | | | | | | **Copy of Card?** |
| Medicare A | | |  | | | | | | |  | | | | | |  |
| Medicare B | | |  | | | | | | |  | | | | | |  |
| Medicare D | | |  | | | | | | |  | | | | | |  |
| Medicaid Case # | | |  | | | | | | |  | | | | | |  |
| Medicaid ID # | | |  | | | | | | |  | | | | | |  |
| VA Health | | |  | | | | | | |  | | | | | |  |
| Private | | |  | | | | | | |  | | | | | |  |
| Supplemental | | |  | | | | | | |  | | | | | |  |
| Other | | |  | | | | | | |  | | | | | |  |
| 1. ADULT RELATIVES, SIGNIFICANT OTHERS And  EMERGENCY CONTACT | | | | | | | | | | | | | | | | |
| Full Name: Emergency Contact \_\_\_\_ Yes \_\_\_No  Full Address:  Verified Phone #:  Relationship to Proposed Ward:  Date of Contact:  Method of Contact:  Reason he/she has refused to act as guardian: | | | | | | | | | | | | | | | | |
| Full Name: Emergency Contact \_\_\_\_ Yes \_\_\_No  Full Address:  Verified Phone #:  Relationship to Proposed Ward:  Date of Contact:  Method of Contact:  Reason he/she has refused to act as guardian: | | | | | | | | | | | | | | | | |
| Full Name:  Full Address:  Verified Phone #:  Relationship to Proposed Ward:  Date of Contact:  Method of Contact:  Reason he/she has refused to act as guardian: | | | | | | | | | | | | | | | | |
| Full Name:  Full Address:  Verified Phone #:  Relationship to Proposed Ward:  Date of Contact:  Method of Contact:  Reason he/she has refused to act as guardian: | | | | | | | | | | | | | | | | |
| Full Name:  Full Address:  Verified Phone #:  Relationship to Proposed Ward:  Date of Contact:  Method of Contact:  Reason he/she has refused to act as guardian: | | | | | | | | | | | | | | | | |
| 1. FUTURE ARRANGEMENTS | | | | | | | | | | | | | | | | |
| Do you have knowledge of an existing will? Yes (attach copy if available) No | | | | | | | | | | | | | | | | |
| Is there an Advance Directive? Yes (Date and Location of Document)  No | | | | | | | | | | | | | | | | |
| Is there a Do Not Resuscitate Order Currently in place \_\_\_ Yes \_\_\_ No | | | | | | | | | | | | | | | | |
| Is this person a designated organ donor \_\_\_ yes \_\_\_ No | | | | | | | | | | | | | | | | |
| Are there existing funeral arrangements?  Funeral Home:  Cemetery:  Irrevocable: Yes No  Amount owed: | | | | | | | | | | | | | | | | |
| 1. INCOME | | | | | | | | | | | | | | | | |
| **Source** | | | | **Monthly Amount OR Date of Application** | | | | | | | **Payee? If so, please list** | | | | | |
| SSA/SSD | | | |  | | | | | | |  | | | | | |
| SSI | | | |  | | | | | | |  | | | | | |
| Veterans Benefits | | | |  | | | | | | |  | | | | | |
| Railroad | | | |  | | | | | | |  | | | | | |
| Pension/Annuity | | | |  | | | | | | |  | | | | | |
| Other | | | |  | | | | | | |  | | | | | |
| Other | | | |  | | | | | | |  | | | | | |
| Other | | | |  | | | | | | |  | | | | | |
| 1. FINANCIAL ACCOUNTS | | | | | | | | | | | | | | | | |
| **Account Type** | | **Location** | | | | **Account Number** | | | | | | **Approximate Value** | | | **Any name in addition to proposed ward’s?** | |
| Checking | |  | | | |  | | | | | |  | | |  | |
| Checking | |  | | | |  | | | | | |  | | |  | |
| Savings | |  | | | |  | | | | | |  | | |  | |
| Savings | |  | | | |  | | | | | |  | | |  | |
| CD | |  | | | |  | | | | | |  | | |  | |
| CD | |  | | | |  | | | | | |  | | |  | |
| IRA | |  | | | |  | | | | | |  | | |  | |
| Stocks/Bonds | |  | | | |  | | | | | |  | | |  | |
| Stocks/Bonds | |  | | | |  | | | | | |  | | |  | |
| Patient Trust Account | |  | | | |  | | | | | |  | | |  | |
| Other | |  | | | |  | | | | | |  | | |  | |
| Other | |  | | | |  | | | | | |  | | |  | |
| 1. ASSETS | | | | | | | | | | | | | | | | |
| **Type** | | **Location and/or Make and Model** | | | | | **Approximate Value** | | | | | | **Monthly payment, if applicable** | | **Any name in addition to proposed ward’s?** | |
| Real Property - House | |  | | | | |  | | | | | |  | |  | |
| Real Property - Land | |  | | | | |  | | | | | |  | |  | |
| Mobile Home | |  | | | | |  | | | | | |  | |  | |
| Vehicle | |  | | | | |  | | | | | |  | |  | |
| Vehicle | |  | | | | |  | | | | | |  | |  | |
| Life Insurance Policy | |  | | | | |  | | | | | |  | |  | |
| Burial Plot | |  | | | | |  | | | | | |  | |  | |
| Burial Plan | |  | | | | |  | | | | | |  | |  | |
| Cash | |  | | | | |  | | | | | |  | |  | |
| Safety Deposit Box | |  | | | | |  | | | | | |  | |  | |
| Other | |  | | | | |  | | | | | |  | |  | |
|  | |  | | | | |  | | | | | |  | |  | |
| 1. Expenses/ Outstanding Debt | | | | | | | | | | | | | | | | |
| Type | | | Creditor | | | | | | | | | BALANCE | | | | |
| Housing/Care | | |  | | | | | | | | |  | | | | |
| Automobile | | |  | | | | | | | | |  | | | | |
| Medical | | |  | | | | | | | | |  | | | | |
| Medical | | |  | | | | | | | | |  | | | | |
| Loan | | |  | | | | | | | | |  | | | | |
|  | | |  | | | | | | | | |  | | | | |
|  | | |  | | | | | | | | |  | | | | |
| 1. ADDITIONAL INFORMATION | | | | | | | | | | | | | | | | |
| Is there any additional information you would like us to know? | | | | | | | | | | | | | | | | |

*CHS 2/12/2018*