



Referral for Guardianship Services

Client's Name: _____
(Please Print) First M.Initial Last

Current Address: _____
Nursing Facility: _____ Admission Date: _____
Home Address: _____

Status of Home: Own Rent Apartment? Yes No

Live alone? Yes No If No, with whom? _____

Previous Address: _____

Referring Agency: _____

Contact Person: _____ Relationship to Person: _____

Phone #: _____ Fax#: _____

Date of Birth: ___/___/___

Place of Birth: _____ U.S. Citizen: Yes No

Social Security #: _____ Race: _____

Medicare #: _____ Medicaid #: _____

Has Adult Protective Services been involved with this client? Yes No

Describe the client's ability to communicate with others: _____

Please list any and all family members:

<u>Name</u>	<u>Relationship</u>	<u>Address</u>	<u>Phone #</u>	<u>Involvement level</u>		
				<u>Very</u>	<u>Some</u>	<u>Never</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Please list any involved friends:

<u>Name</u>	<u>Address</u>	<u>Phone #</u>
_____	_____	_____
_____	_____	_____

Spouse Information

Spouse's Name: _____ SS#: _____
Current status: Divorced (Date): _____ Deceased (Date): _____
Spouse's Birth Date: _____
Military Service: Yes No Branch: _____ Discharge Date: _____
Former Spouse(s): _____

Financial Information

Monthly Income:(i.e. Social Security, Pensions, Annuities, etc.)

Amount: \$ _____ Source: _____
Amount: \$ _____ Source: _____
Amount: \$ _____ Source: _____

Bank Account: Yes No Name of Bank: _____
Bank Address: _____ Phone#: _____
Contact Person: _____ Title: _____

Checking Account: Yes No Acct. #: _____
Savings Account: Yes No Acct. #: _____
Money Market: Yes No Pertinent Info: _____
C.D.'s: Yes No Pertinent Info: _____
Stocks: Yes No Pertinent Info: _____
Bonds: Yes No Pertinent Info: _____

Current Debts and Creditors (Total Amounts):

Rent: \$ _____ Mortgage: \$ _____ Loans: \$ _____ Utilities: \$ _____
Other: \$ _____
Credit Cards: \$ _____ Credit Card Company(s): _____

Legal Information

Is there currently a legal guardian, Power-of-Attorney, or other advocate? Yes No

(Please list or include copies of any information pertaining to this.) _____

Does the client have legal representation? Yes No

(Please list name, address & phone#): _____

Does the client have a will? Yes No Name of will holder: _____

Any pending legal action? Yes No Describe: _____

Health Insurance

Medicare: Yes No **Type:** Part A Part B Part D

Medicare D Provider: _____ Policy # : _____

Medicare Replacement Insurance: Yes No

Provider: _____ Policy # : _____

Medicaid: Yes No Caseworker's Name: _____ Phone#: _____

Other (Supplemental Health) Insurance: Yes No

Company name: _____ Policy#: _____

Address: _____

Phone #: _____ Monthly premium: \$ _____

Medical Information

Physicians Name: _____ Eye Doctor's Name: _____

Dentist's Name: _____ Psychiatrist's Name: _____

Current Diagnosis (Please Attach History and Physical Report): _____

Advance Directives: Full code No code Living Will

Are there any immediate health care concerns to be addressed? _____

Real Estate

Please complete this section only if client owns real estate.

Address of Property: _____

Property Type: House Mobile Home Other: _____

Previous Address: _____

Mortgage Type: Traditional Reverse Balloon

Mortgage paid in full? Yes No Total owed \$ _____ Monthly payment \$ _____

Mortgage Company Name _____

Address: _____ Phone #: _____

Years Owned: _____ Are there liens against property? Yes No

Lien Holder: _____ Amount Owed: \$ _____

Are taxes current? Yes No Back Taxes Owed: \$ _____

Is a tax sale in process? Yes No

Vehicles

Current or Recently Owned Vehicles

Make _____ Model _____ Year _____

Owned Currently? Yes No If Sold, Date of Sale: _____

Car Payments: \$ _____ Location of Car: _____

Life Insurance

Life Insurance: Yes No Company Name: _____

Address: _____ Phone #: _____

Policy # _____

Whole Life Insurance? Yes No Term Insurance: Yes No

Paid in full? Yes No Monthly premium \$ _____

Name of Beneficiary: _____

Address: _____

Phone #: _____

Funeral/Burial Arrangements

Funeral Home: _____ **Contact Person:** _____

Address: _____

Phone#: _____ **Fax#:** _____

Pre-Paid Plan or Trust? Yes No Pd in full **Amount Owed: \$** _____

Company Name: _____ **Policy#:** _____

Burial **Cremation** **Amount owed:** _____

Cemetery: _____ **Contact Person:** _____

Address: _____ **Phone#:** _____

Own Lot? Yes No **Paid in Full?** Yes No **Amount Owed:\$** _____

Location of Lot: _____

Own Vault? Yes No **Paid in Full?** Yes No **Amount Owed:\$** _____

Own Headstone? Yes No **Paid in Full?** Yes No **Amount Owed:\$** _____

Own Marker? Yes No **Paid in Full?** Yes No **Amount Owed:\$** _____

Other

Religious Preference: _____

Church Preference: _____

Education: 8th Grade or Less 12th Grade or Less
 High School Graduate Post High School Degree

Other Pertinent Information

Why is guardianship being pursued? _____

Is this individual receiving any additional services with REAL Services, Inc.? Yes No

Please provide any additional information which you feel would be useful in determining whether this client is eligible for the REAL Services' Guardianship

Program: _____

Signature
(required)

Signature of Person Completing This Form: _____

Relationship to Client: _____ **Date:** _____

Note: This Referral must be accompanied by a signed Physician's report verifying mental incapacitation and need for a guardian. Please also attach a recent History and Physical for the client.

Please return completed referral to:
REAL Services, Inc.
Attention: Guardianship Coordinator
P.O. Box 1835
South Bend IN, 46634
Phone: 574-284-7178 Fax: 574-284-2693
Email: cbower@realservices.org

4-09