Referral for Guardianship Services

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

Current Address:
Nursing Facility: ____________________ Admission Date: ________________

Home Address: ____

Phone #:____

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 ID#**: ______________________

Case #: __________________________

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:

Name	Relationship	Address	Phone #	Involvement level Very Some Never

Please list any involved friends:

Name	Address	Phone #	

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?____

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____

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: ___________

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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
P.O. Box 1835
South Bend IN, 46634
Phone: 574-284-2649 Fax: 574-284-2691
Email: guardianship@realservices.org

Clients do not receive any financial remuneration through CDBG, CSBG, or any other funds.

Updated 9.12.19