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?_____

_____

_____

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
P.O. Box 1835
South Bend IN, 46634
Phone: 574-284-2649 Fax: 15749661439
Email: guardianship@realservices.org

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

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