

GUARDIANSHIP AND PROTECTIVE SERVICES, INC.
197 W. Market Street, 2nd Floor ■ Warren, OH 44481
Phone: 330-299-0267 ■ Fax: 330-399-4277

REFERRAL FOR SERVICES

Date: _____

Referral Source

Name: _____ Position: _____

Agency/Facility: _____ Phone: _____ Fax: _____

Address: _____

Consumer Information

Name (First, Middle, Last): _____ Gender: _____

DOB: _____ SSN: _____ Marital Status: _____

Home Address: _____ City: _____ Zip: _____

Current Location: _____

Reason for Admission: _____

Admission Date: _____ Expected Discharge Date: _____

*Attach admission sheet for additional information

Spouse's Name (if applicable): _____

DOB: _____ SSN: _____ Phone: _____

Home Address: _____ City: _____ Zip: _____

Guardianship Need

Urgency: Non-Emergency Emergency

Type: Person Estate Person & Estate Conservatorship

Explain Need for Guardianship: _____

Other Agencies involved and services received (during last 12 months): _____

Adult Protective Services Information (If applicable):

APS order requested from Probate Court: No Yes/Date: _____

Reason for APS involvement: _____

Consumer has past involvement with APS: No Yes/Date(s): _____

Explain Outcome: _____

Social History: Attached

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Current Medical Conditions: Attached

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Current Medications: Attached

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Recent Nursing Facility Admission (Reason/Dates): _____

Recent Hospitalizations (Reason/Dates): _____

Primary Physician: _____

Date of last appointment: _____ Reason: _____

Current Psychiatrist or Psychologist: _____

Date of last appointment: _____ Reason: _____

Consumer has involvement with the Mental Health system: No Yes

Agency: _____ Phone: _____

Case Manager: _____ Therapist/Doctor: _____

History: _____

Describe any exhibited mental health symptoms (ie. hallucinations, delusions, recent losses, sleep problems, etc.): _____

Describe consumer's ability to perform ADL's and IADL's (ie. bathing, dressing, shopping, preparing meals, telephone etc.): _____

Describe ability to ambulate: _____

Financial

Person who manages consumer's financial affairs: _____

Consumer has unpaid bills: No Yes _____

Financial Resources (include source, amount and account number where applicable):

| Monthly Income | Assets |
|---------------------|----------------|
| Social Security: | Checking Acct: |
| SSI: | Savings Acct: |
| VA Benefits: | Real Estate: |
| Pension: | Auto: |
| Other: | Investment: |
| Interest/Dividends: | |

Health Insurance: Attached

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|-------------------------------|
| Medicare #: |
| Medicaid #: |
| Medicare HMO Company and #: |
| Other Health Insurance and #: |

DNR Status: _____

Consumer has a Living Will: No Yes

Consumer has a prepaid funeral fund: No Yes/Where: _____

*Please attach financial documents, Living Will, funeral arrangement

Family/ Other Contacts:

| Name | Relationship | Address | Phone |
|------|--------------|---------|-------|
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Your signature below verifies that all potential applicants have been asked to serve and have declined to serve as guardian/conservator. (required)

Signature: _____

FOR GUARDIANSHIP AND PROTECTIVE SERVICES USE

Date Referral Received: _____ **Received By:** _____

Statement of Expert Evaluation Original **Next-of-Kin Form**
 Statement from Referral Source **Assessment Complete/Date:** _____
 Referral Complete/Date: _____

Approval to File Application/Date and Initials: _____
 Person **Estate** **Person & Estate** **Conservatorship**

Referral Closed/Date/Reason: _____