GUARDIANSHIP AND PROTECTIVE SERVICES, INC.
1371 Church St. ▪ Mineral Ridge, Ohio 44440
Phone: 330-299-0267 ▪ Fax: 330-349-0427

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 (must provide additional form)

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

Current Medical Conditions: ☐ Attached

Current Medications: ☐ Attached

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: _____

<u>Financial</u>

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

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

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:_____**

Clear

PROBATE COURT OF TRUMBULL COUNTY, OHIO
THOMAS A. SWIFT, JUDGE

IN THE MATTER OF THE GUARDIANSHIP OF _____

CASE NO. _____

NEXT OF KIN OF PROPOSED WARD

(R.C. 2111.04)

(NOTE: Specify age and birthdate of each minor under 16 on the line containing the minor's name. List the name and address of the minor's parent, guardian or custodian on the name and address lines following the minor's address.)

	Service Waived		Relationship	Birthdate Of Minor
1.	☐	Name _____	_____	_____
		Address _____		Zip _____
2.	☐	Name _____	_____	_____
		Address _____		Zip _____
3.	☐	Name _____	_____	_____
		Address _____		Zip _____
4.	☐	Name _____	_____	_____
		Address _____		Zip _____
5.	☐	Name _____	_____	_____
		Address _____		Zip _____
6.	☐	Name _____	_____	_____
		Address _____		Zip _____
7.	☐	Name _____	_____	_____
		Address _____		Zip _____
8.	☐	Name _____	_____	_____
		Address _____		Zip _____
9.	☐	Name _____	_____	_____
		Address _____		Zip _____
10.	☐	Name _____	_____	_____
		Address _____		Zip _____

_____ Date

_____ Applicant

CLEAR

PROBATE COURT OF TRUMBULL COUNTY, OHIO

IN THE MATTER OF THE GUARDIANSHIP OF _____

CASE NO. _____

STATEMENT OF EXPERT EVALUATION

[Sup. R. 66 & R.C. 2111.49]

Definition of Incompetent (R.C. 2111.01(D)): "'Incompetent' means any person who is so mentally impaired as a result of a mental or physical illness or disability, or mental retardation, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person's self or property or fails to provide for the person's family or other persons for whom the person is charged by law to provide, or any person confined to a correctional institution within this State."

The Statement of Evaluation does not declare the individual competent or incompetent, but is evidence to be considered by the Court. The fee for completing this evaluation **WILL NOT** be paid by the Probate Court. Each evaluator should secure payment from the Applicant/Guardian.

1. This Statement of Expert Evaluation is to be filed with or attached to:

☐ A. Guardianship Application: Completed by ☐ Licensed Physician or ☐ Licensed Clinical Psychologist prior to the filing and attached to the application.

☐ B. Guardian's Report: Completed by ☐ Licensed Physician ☐ Licensed Clinical Psychologist ☐ Licensed Independent Social Worker ☐ Licensed Professional Clinical Counselor or ☐ Mental Retardation Team.
The evaluation or examination shall be completed within three months prior to the date of the Report. R.C. 2111.49

☐ C. Application for Emergency Guardian: ☐ of the person: a Licensed Physician shall complete the Supplement for Emergency Guardian, form 17.1A with specificity indicating the emergency, and why immediate action is required to prevent significant injury to the person. The Supplement shall be signed, dated, and attached as part of this completed Statement.

2. Statement completed by:

Name & Title/Profession: _____

Business Address _____

Business Telephone Number _____

3. Date(s) of evaluation: _____

Place(s) of evaluation: _____

Amount of time spent on evaluation: _____

Length of time the individual has been your patient: _____

CASE NO._____

4. Is the individual presently under medication? ☐ Yes ☐ No If yes, what is the medication, dosage, and purpose?

_____

Are there any signs of physical and/or mental impairments caused by the medications themselves?

_____

5. Is the individual mentally impaired? ☐ Yes ☐ No If yes, indicate the diagnosis below:

☐ Mental Retardation/Developmental Disabilities:

☐ Profound ☐ Severe ☐ Moderate ☐ Mild

☐ Mental Illness: Type and Severity

_____

☐ Substance Abuse: Description _____

_____

☐ Dementia: Description _____

_____

☐ Other: Description _____

_____

Please provide additional comments and test scores if available. (Continue comments on page 4):

_____

6. During the examination did you notice an impairment of the individual's:

a)	Orientation	☐ Yes	☐ No	☐ Unknown
b)	Speech	☐ Yes	☐ No	☐ Unknown
c)	Motor Behavior	☐ Yes	☐ No	☐ Unknown
d)	Thought Process	☐ Yes	☐ No	☐ Unknown
e)	Affect	☐ Yes	☐ No	☐ Unknown
f)	Memory	☐ Yes	☐ No	☐ Unknown
g)	Concentration and comprehension	☐ Yes	☐ No	☐ Unknown
h)	Judgment	☐ Yes	☐ No	☐ Unknown

7. Please describe any impairments identified in question six. (Continue comments on page 4).

_____

CASE NO._____

8. Is the individual physically impaired? ☐ Yes ☐ No If yes: Description

_____

9. Are there any special characteristics of the individual which should be considered in evaluating the individual for guardianship? ☐ Yes ☐ No If yes: Explain

_____

_____

10. Are there any indications of abuse, neglect or exploitation of the individual? ☐ Yes ☐ No
If yes: Explain _____

_____

11. Do you believe the individual is capable of caring for the individual's activities of daily living or making decisions concerning medical treatments, living arrangements and diet? ☐ Yes ☐ No

If no: Explain _____

12. Do you believe this individual is capable of managing the individual's finances and property?
☐ Yes ☐ No If no: Explain

_____

13. Prognosis:
A. Is the condition stabilized? ☐ Yes ☐ No
B. Is the condition reversible? ☐ Yes ☐ No

14. In my opinion a guardianship should be:
☐ Established/Continued
☐ Denied/Terminated

I certify that I have evaluated the individual on _____, 20_____.

Date: _____ _____
Signature of Evaluator

GUARDIAN'S REPORT ADDENDUM

(Not to be used with initial Application)

It is my opinion, based upon a reasonable degree of medical or psychological certainty, that the mental capacity of this ward will not improve.

Date _____ _____
Signature - Licensed Physician/Clinical Psychologist

CASE NO._____

ADDITIONAL COMMENTS

Date _____

_____
Signature - Licensed Physician/Clinical Psychologist