



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 Some 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

