(INSERT LETTER HEAD)

Community Referral Form for Guardianship and Protective Placement

Complete the attached form to make a referral for Guardianship of the Person, Guardianship of the Estate and/or Protective Placement to County Adult Protective Services (APS). A phone call to APS is needed prior to submitting this form. Please call and ask to speak to an Adult Guardianship Program (AGP) Social Worker in the Adult Protective Services Unit.

Before a community referral case is assigned to an APS AGP social worker the following documents MUST be provided:

* Community Referral Form
* Examining Physician or Psychologist Report. The determination of incompetence is dependent upon a medical report of a physician, psychiatrist or psychologist.
* A short written narrative, stating why a guardian of the person and/or estate is needed plus what less restrictive actions have been taken to permit this person to care for themselves without a guardian or protective placement. If Protective Placement is also being requested, explain the reason it is necessary.

|  |  |
| --- | --- |
| **Individual Being Referred** | |
|  | |
| Client Name | Address |
| (First, Middle, Last) | (Street, City, State, Zip code) |
| Home Phone | Date of Birth |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Finances** | | | | |
|  | | | | |
| Monthly Income from Social Security |  |  | Monthly Income from SSI |  |
|  |  |  |  |  |
| Monthly Income from SSDI |  |  | Monthly Income from VA |  |
|  |  |  |  |  |
| Monthly Gross Earnings |  |  | Any other Income – Specify Source of Income |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the Individual:** | |  | |
|  | Own Property?  Yes  No | Own a Home? Value of home |  |
|  | On Medical Assistance?  Yes  No |  | |
|  | Have a Trust? (List type of trust and amount) |  | |
|  | Have a Case Manager or Support Broker? (Provide name, phone number, address and email) | | |
|  |  | | |
|  | Working with a MCO? (Provide agency’s name, care manager’s phone number, address and email) | | |
|  |  | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Guardian Information** | | | | | | | |
|  | | | | | | | |
| Please check the box(es) that are applicable: | | | | | | | |
| Guardian of Person |  | Guardian of Estate |  | Guardian of Person and Estate |  | Protective Placement |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Proposed Guardian |  | Proposed Standby Guardian (OPTIONAL) |
| Legal Name: |  | Legal Name: |  |
| Address: |  | Address: |  |
| City/St/Zip: |  | City/St/Zip: |  |
| Home Phone: |  | Home Phone: |  |
| Work Phone: |  | Work Phone: |  |
| Cell Phone: |  | Cell Phone: |  |
| Email Address: |  | Email Address: |  |

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| --- |
| **Notification** |

BY STATUTE, FAMILY MEMBERS MUST BE NOTICED OF GUARDIAN PROCEEDINGS. Please list family members and contact information, including estranged family members below. Start with the individual(s) as stated below:

* Spouse - If the person is married then information about below entities is not needed.
* All adult children, including by adoption - If the person has adult children then information about below entities is not needed.
* All adult grandchildren and great grandchildren - If the person has adult grandchildren then information about below entities is not needed
* Parent (s) - If the person has a parent then information about below entities is not needed.
* Siblings - If the person has a sibling then information about below entities is not needed.
* Adult children of siblings

|  | **Name** | **Last Known Address** | **Phone # and Email:** |
| --- | --- | --- | --- |
| Partner / Spouse |  |  |  |
| Living Adult Children |  |  |  |
| Living Adult Grand -children |  |  |  |
| Parent (s) |  |  |  |
| Living  Siblings |  |  |  |
| Adult Children of Siblings |  |  |  |
| Rep Payee |  |  |  |
| POAHC  Agent \*\* |  |  |  |
| DPOA  Agent \*\* |  |  |  |

**\*\* If this person has Advanced Directives such as Power of Attorney for Health Care or Durable Power of Attorney for Finances, please attach a copy.**

# Before submitting/submission to Adult Guardianship Program make sure you have done the following:

|  |  |
| --- | --- |
|  | Called and spoke with an Adult Guardianship Program Social Worker. |
|  | NARRATIVE as to why Guardianship and/or Protective Placement is needed. |
|  | Attach the **original** Examining Physician’s Report. This document must be signed and dated by the physician/psychologist. The physician/psychologist who met with the patient must be willing to testify to the content of the report. |
|  | Attach Power of Attorney for Health Care, if it exists. Include the activation page signed by 2 physicians, if applicable. |
|  | Attach Durable Power of Attorney for Finances if the document(s) exist. |

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| **Person Making Referral** |

Name/Relationship

Agency

Address

City/State/Zip

Phone

E-mail

***MAIL THIS REFERRAL FORM WITH NARRATIVE and COMPLETED ORIGINAL EXAMINING PHYSICIAN’S REPORT TO:***

(INSERT APS NAME AND ADDRESS)