Family Care/IRIS Referral for APS Services:

EA (Elder Abuse), AAR (Adults-at-Risk), Guardianship (Ch. 54), Protective Services (Ch.55), & Mental Health (Ch. 51) for GSRs: 1, 3, 5, & 5/6.

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| **Date:** |  |

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| **Member Information** |
| **Member Name:** |  | [ ]  F [ ]  M | DOB: |  |
| **Street Address:** |  | **City:**  |  | **State, Zip:** |  |
| **Marital Status:** | [ ]  Single [ ]  Married [ ]  Divorced [ ]  Widowed |
| **County of Residence:** |  | **County of Responsibility:** |  |

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| **Purpose of Referral** |
| [ ]  Adult at Risk (age 18-59) [ ]  Elder Abuse (age 60 and over) |
| Describe the situation related to abuse, neglect, self-neglect, or financial exploitation: |
|  |
| [ ]  Guardianship [ ]  Protective Services/Placement [ ]  Other (specify):  |       |

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| **Referral Information** |
|  | Address: |  |
| [ ]  Power of Attorney (POA) Activated: [ ]  Yes [ ]  No | Name: |       | Phone #: |       |
| Address: |       |
| [ ]  Representative Payee | Name: |  | Phone #: |  |
| Address: |  |
| Primary Physician Name: |  | Phone #: |  |
| Clinic Address: |  |
| Primary Diagnosis: |  |
|  Name: |  | Phone #: |  |
| Office City: |  | Email: |  |

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| **Contact Information** *(Complete if only for guardianship)* |
| Name: |       |
| Address: |       | City: |       | State, Zip: |       |
| Phone #: |       | [ ]  Spouse [ ]  Other (specify): |       |
| Name: |       |
| Address: |       | City: |       | State, Zip: |       |
| Phone #: |       | [ ]  Spouse [ ]  Other (specify): |       |
| Name: |       |
| Address: |       | City: |       | State, Zip: |       |
| Phone #: |       | [ ]  Spouse [ ]  Other (specify): |       |