COUNTY HUMAN SERVICES DEPARTMENT REQUEST FOR GUARDIANSHIP EXTERNAL AGENCIES

Name of staff making request: Date of request:

CLIENT’S NAME: DOB:

CURRENT ADDRESS:

PHONE: MCO/IRIS:

TYPE OF RESIDENCE (personal home, apartment, CBRF, AFH):

REFERRAL FOR (please check all that apply):

Guardian of person Guardian of Estate Protective Placement

Protective Services (i.e. psych. med referral) Other (ex: successor guardian)

IS THERE A POA (POWER OF ATTORNEY) DOCUMENT? NO YES (attach a copy)

IS THERE A REP PAYEE? NO YES WHO?

DOES THE CLIENT HAVE?

Medical Assistance Medicare Part A Part B Part C Part D

VA benefits Other benefits (Family Care, IRIS) SSI

CLIENT’S PRIMARY PHYSICIAN:

CLIENT’S OUTPATIENT MENTAL HEALTH PROVIDER:

Is the physician willing to complete the Examining Physician’s Report? No Yes

Fax # or mailing address:

CLIENT’S ASSET INFORMATION:

Does the client own property? No Yes (Approximate value: )

Current amount in checking account: Current amount in savings account:

Monthly income and source (i.e. SSI, pension, Social Security):

Is there a burial trust? No Yes (List value: )

PLEASE LIST (include first and last names, complete address information, and phone numbers): Proposed guardian:

Proposed standby:

Spouse:

Adult children (living or deceased):

If there is no spouse or adult children, list mother, father, adult siblings, close friends (include first and last names, complete address, and phone number):

\*In addition to the above information, please attach a written explanation of why you feel pursuing Guardianship/Protective Plan is necessary.

If this form is not completed entirely, it may be returned for completion. Feel free to attach additional pages if there is not sufficient room on this form. If there are questions, please feel free to contact, APS Supervisor, at .

**Return completed form via mail or scanned electronically to:**

 , APS Supervisor

 County Human Services-Adult Protective Services

Add County Address

Add Phone and email