Guardianship Referral Form

Date of Referral: _____ Referring Agency: _____

Name of Referral Contact: _____
First Last

Relationship to Client: _____

Referral Contact Phone: _____ Email: _____

Client Demographics

Full Name: _____
First Middle I. Last

Preferred Name: _____

Social Security Number: _____

Date of Birth: _____ Age: _____

Ethnicity: _____

☐ Male ☐ Female ☐ Transgender ☐ Other

Home Address: _____
Street City State Zip

Phone Number: _____

Marital Status: _____ U.S. Citizen? ☐ Yes ☐ No

Type of Housing:

☐ Supportive Living ☐ Residential Care Facility ☐ ICF ☐ Respite

☐ Assisted Living Facility ☐ Group Home ☐ Apartment ☐ Condo

☐ House ☐ Trailer ☐ Homeless/Homeless Shelter: _____

☐ Nursing Facility ☐ Locked Unit? ☐ Yes ☐ No

Living Arrangements *(Please check all that apply)***:**

☐ Alone ☐ With Spouse ☐ With Relative ☐ With Unrelated

☐ Staff Present Other: _____

Date Began Living at Residence: _____ Staffing Agency: _____

Contact Person: _____

Contact Phone: _____ Email: _____

Current Placement Address, if different than home address: _____
Street

_____
City State Zip Code

Placement Type**:**

☐ Respite ☐ Hospital ☐ Short Term Rehab Facility

☐ Other: _____

Contact Person: _____

Contact Phone: _____ Email: _____

Date of Admission: _____

Does the prospective ward leave the above address during the day? ☐ Yes ☐ No

If yes, they go to:

☐ Work

Name of Employer: _____

☐ Regular Scheduled Programming

Name of Program Manager: _____

Contact Information: _____

☐ School

Name of School: _____

Contact Person: _____

☐ Other: _____

Contact Person: _____

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

Time Gone During Day: _____

Communication Considerations

Spoken Language: _____

☐ Sign Language ☐ Non-Verbal ☐ Hard of Hearing

Communication Barriers: _____

Medical

Medical and Mental Health Diagnoses:

Medications:

Allergies:

History of Substance Abuse:

History/Patterns of Hospitalizations:

Treating Medical and Mental Health Providers

Contact Name: _____

Address: _____
Street City State Zip Code

Telephone: _____ Specialty: _____

Upcoming Appointments: _____

Contact Name: _____

Address: _____
Street City State Zip Code

Telephone: _____ Specialty: _____

Upcoming Appointments: _____

Contact Name: _____

Address: _____
Street City State Zip Code

Telephone: _____ Specialty: _____

Upcoming Appointments: _____

If there are additional treating physicians, please include in the additional comments section.

Behaviors:

Financial

Does the individual have a representative payee? ☐ Yes ☐ No

If yes, contact name and phone number: _____

Do they have a bank account? ☐ Yes ☐ No

If yes, what bank? _____

Monthly income amount, total:

Type of Income:

SSA, $ _____ SSI, $ _____

SSDI, $ _____ VA, $ _____

Pension, $ _____ Pension, $ _____

Type: _____

Other, $ _____

Type: _____

Insurance Information:

☐ Medicaid, # _____

☐ Medicare, # _____

☐ Private Insurance, # _____

Assets:

Property, $ _____

Other, $ _____

Trust, $ _____

Probate Court Case Information, if applicable N/A ☐

Probate Court Case No.: _____

Current Guardian of Person: _____

Contact Information: _____

Guardian of Estate: _____

Contact Information: _____

Has the Statement of Expert Evaluation been dispensed? ☐ Yes ☐ No

Date Dispensed: _____

Date of Initial Guardianship: _____

Family and Other Known Supports

Please list all known family regardless of involvement. Also list any other informal supports involved with the client.

Name: _____
First Middle I Last

Relationship: _____

Address: _____
Street City State Zip Code

Telephone: _____ Is this person actively involved? ☐ Yes ☐ No

Name: _____
First Middle I Last

Relationship: _____

Address: _____
Street City State Zip Code

Telephone: _____ Is this person actively involved? ☐ Yes ☐ No

Name: _____
First Middle I Last

Relationship: _____

Address: _____
Street City State Zip Code

Telephone: _____ Is this person actively involved? ☐ Yes ☐ No

Name: _____
First Middle I Last

Relationship: _____

Address: _____
Street City State Zip Code

Telephone: _____ Is this person actively involved? ☐ Yes ☐ No

Name: _____
First Middle I Last

Relationship: _____

Address: _____
Street City State Zip Code

Telephone: _____ Is this person actively involved? ☐ Yes ☐ No

Name: _____
First Middle I Last

Relationship: _____

Address: _____
Street City State Zip Code

Telephone: _____ Is this person actively involved? ☐ Yes ☐ No

Please include any additional family and/or other supports in the additional comments.

Presenting Circumstances:

Other Situational or Special Circumstances:

If GSB is appointed as guardian, what decisions are anticipated within the first month?

Safety Concerns:

☐ Weapons in the Home ☐ Animals ☐ Bedbugs ☐ Cockroaches

☐ Mice/Rats ☐ Hoarding ☐ Structural Concerns ☐ Drug Activity

☐ Potential Verbal Violence ☐ Potential Physical Violence

Other: _____

<u>The GSB is the *guardian of last resort*, therefore the following steps are *required*:</u>

Have the following attorneys/organizations been contacted prior to making a referral to the GSB?

Attorneys: ☐ Yes ☐ No

Name: _____

Response: _____

Name: _____

Response: _____

Name: _____

Response: _____

Volunteer Guardianship Program (VGP): ☐ Yes ☐ No

Response: _____

Advocacy and Protective Services Inc.(APSI): ☐ Yes ☐ No

Response: _____

Please include any supporting documentation such as: ISP, BSP, Treatment Plan, History and Physical, Face Sheet, etc.

Additional Comments:

If more space is needed, please attach separately.

Send the completed, original Statement of Expert Evaluation to:
Attn: Guardianship Service Board
373 S. High Street, 11th Floor, Columbus, Ohio 43215.