



Guardianship Referral Form

Date of Referral: _____ Referring Agency: _____

Name of Referral Contact: _____
First Last

Referrer Title: _____

Referral Contact Phone: _____ Email: _____

Client Demographics

Full Name: _____
First Middle I. Last

Social Security Number: _____ Date of Birth: _____ Age: _____

Race/Ethnicity: _____ US Citizen? Yes No

Gender: Male Female Transgender Unspecified

Home Address: _____
Street City State Zip

Phone number/type: _____ Marital Status: _____

Primary Language: _____ Interpreter needed/Type? _____

Communication Barriers: Non-Verbal Hard of Hearing Other: _____

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: _____

Contact Person/relationship: _____

Contact Phone Number: _____ Email: _____

Current Placement Address, if different than home address:

Street City State Zip Code

Date of Admission/Placement: _____

Placement Type:

Respite Hospital Short Term Rehab Facility

Other: _____

If other who else resides there: _____

Contact Person/relationship: _____ Phone number: _____

Email: _____

If client is currently hospitalized: Discharge plan (if skilled nursing placement is needed, provide rational) and Estimated Discharge Date:

Reason for Referral/Presenting Circumstances (provide detailed information including on-going concerns and reasons why a guardian is needed):

Other Situational or Special Circumstances (include family dynamics, concerns etc...):

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: _____

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

If yes:

Monday Tues Wed Thurs Fri

Between the hours of: _____

Work

Name of Employer and contact information: _____

Regular Scheduled Programming

Name and type of Program: _____

Contact Information: _____

School

Name of School: _____

Contact Information: _____

Other: _____

Contact Information: _____

Financial

Does the individual have a representative payee? Yes No Unknown

If yes, contact name and phone number: _____

Do they have a bank account? Yes No Unknown

If yes, what bank? _____

Monthly income amount, total:

Type of Income:

SSA, \$ _____

SSI, \$ _____

SSDI, \$ _____

VA, \$ _____

Pension, \$ _____

Pension, \$ _____

Source: _____

Source: _____

Other, \$ _____

Type: _____

Assets:

Property, \$ _____

Trust, \$ _____

Other, \$ _____

Vehicle(s)? Type(s): _____

Insurance:

Medicare ID# _____

Medicaid ID# _____

Private Insurance company and ID: _____

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: _____ Telephone: _____

Address: _____
Street City State Zip Code

Email: _____ Is this person actively involved? Yes No Unknown

Name: _____
First Middle I Last

Relationship: _____ Telephone: _____

Address: _____
Street City State Zip Code

Email: _____ Is this person actively involved? Yes No Unknown

Name: _____
First Middle I Last

Relationship: _____ Telephone: _____

Address: _____
Street City State Zip Code

Email: _____ Is this person actively involved? Yes No Unknown

Name: _____
First Middle I Last

Relationship: _____ Telephone: _____

Address: _____
Street City State Zip Code

Email: _____ Is this person actively involved? Yes No Unknown

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

Medical Information:

Medical Diagnoses:

Allergies:

Mental Health Diagnoses:

The GSB is the *guardian of last resort*, therefore alternative options should be explored prior to a referral.

Family and/or other supports: Yes No

Name and Relation: _____

Response: _____

Name and Relation: _____

Response: _____

Name and Relation: _____

Response: _____

Attorneys/organizations: Yes No

Name: _____

Response: _____

Name: _____

Response: _____

Name: _____

Response: _____

Volunteer Guardianship Program (VGP) (*if over the age of 60*): Yes No N/A

Response: _____

Advocacy and Protective Services, Inc. (APSI) (*if linked with FCBDD*): Yes No N/A

Response: _____

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

Additional Comments:

If more space is needed, please attach separately.

Send the completed, original Statement of Expert Evaluation to:

Attn: Guardianship Service Board

80 East Fulton St 4th floor, Columbus, Ohio 43215

Or email to: GSBreferral@franklincountyohio.gov