Guardianship Referral Application

1900 Fairgrove Ave.
Hamilton, Ohio 45011
Phone: 868-3210, Option 6 Fax: 513-785-4875

Client Name: ______________________ Date: Click or tap to enter a date. ______

Current Address: ______________________ How long at current address: ______

Previous Address: ______________________

______________________ Phone: ______

DOB: ______ SSN: ______

Birth Gender: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female Preferred Pronoun(List): ______

Race: ______ Marital Status: ______ Spouse Name: ______

Facility: ☐ Y ☐ N Facility Name: ______ Admission Date: ______

Current Employment/Retired from: ______________________

Emergency Health Needs: ______________________

Expert Evaluation Completed by and date completed: ______________________

Emergency Guardianship: ☐ Y ☐ N If yes explain why: ______________________

Referral Source: ______________________

Referred/Completed By: ______________________ Phone ______

E-mail address: ______________________

Why Referred? ______________________

Income Source	Amount

Estate Information: ______________________

Own Property: ☐ Y ☐ N Own Car: ☐ Y ☐ N Life Insurance: ☐ Y ☐ N

Checking or Savings Acct: ☐ Y ☐ N if yes where? ______

Current Payee: ☐ Y ☐ N If yes who? ______

Insurance Info: ______

Medicare # ______ Medicaid # ______

Veteran? ☐ Y ☐ N Branch? ______

Please attach copies of Insurance Cards

Current/Previous Guardian ☐ Y ☐ N Court ______

Name: ______ Relationship: Choose an item. ______ Phone: ______

Support System (Include family, friends, neighbors, other contacts) **Family must be contacted about Guardianship referral before sending referral to LifeSpan.**

Name	Relationship to Client	Address	Phone	Contacted in regards to Guardianship Application	Comments

Physicians

Name	**Specialty**	**Phone**

Specific Diagnosis	**Current Medications**

Check all that apply ☐Alzheimer /Dementia ☐ MH ☐MR/DD ☐Physical ☐Substance Abuse

Functional Limitations:

Ambulation:	☐Independent	☐Walker	☐Cane	☐Wheelchair
ADL's:	☐Independent	☐Verbal Prompt	☐Needs Assistance	☐Total Care
Vision:	☐Glasses		☐Legally Blind	
Hearing:	☐Hearing Aids	☐L	☐R	☐Both
Dentures:	☐Upper	☐Lower	☐Both	☐Partial
Prosthesis:	☐ **Y** ☐**N**	Where?		

Formal Care Providers currently involved in case:

Name	Phone	Services provided

Funeral Plans: ☐Y ☐N ☐Prepaid ☐Preplanned

Name of Cemetery: ____________________ Phone: # ____________________

Funeral Home: ______________________ Phone#: ______________________

Religion: ______________________ Church: ______________________

Living Will: ☐ Y ☐ N Where? ______________________

DNR: ☐ Y ☐ N Where? ______________________

DPOA: ☐ Y ☐ N Who is the contact person? ______________________

Legal Proceedings past or present?

Please attach copies as appropriate for client:

**Expert Evaluation – ***required* (forms can be found at below links)

Butler County – https://www.butlercountyprobatecourt.org/pdf/17.1.pdf

Warren County – http://www.warren.oh.us/probate_juvenile/probate/forms/17_01.pdf

Hamilton County – https://www.probate.org/forms/guardianship (Form 17.1)

Current Psychological

DAF – Psychiatric Disability Assessment Form

Face Sheet

Signature of who completed Referral Application and submitted:

____ Date:______________________

Please return completed for via:

Fax: 513-785-4875

Email: smartino@community-first.org

Mail: 1900 Fairgrove Ave, Hamilton, OH 45011 ATTN: Lisa