LIFESPAN
COMMUNITY FIRST SOLUTIONS

Guardianship Referral Application

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

Client Name: _____ 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 Name: _____ ☐ Y ☐ N Court Relationship: _____ 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?

Signature of who completed Referral Application and submitted:

_____ Date:_____

Please attach copies as appropriate for client:

- *Expert Evaluation – ***required***
  - Fill out the appropriate Expert Evaluation form for Butler, Clinton, Hamilton or Warren county.
- Current Psychological
- DAF – Psychiatric Disability Assessment Form
- Face Sheet

Please return completed form via:

Fax: 513-785-4875

Email: snmartino@community-first.org

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

*Original signed signature by physician or licensed clinical psychologist to be mailed to LifeSpan inc. office or can place in agency drop box.