

Guardianship Alliance of Colorado Guardianship Referral Form

Proposed Client Name:	Proposed Client Date of Birth:	Date of Referral:
Referring Party Name:	Referring Party Phone:	Relationship to Proposed Client:
General Information		
Proposed Client Home Address:		
Status of Home (Circle One): Own Rent Other	Living Alone: Yes No	Marital Status:
Nursing Facility:		Date of Admission:
Place of Birth:	Social Security Number:	Medicare Number:
Medicaid ID Number:	Other Insurance Name:	Other Insurance ID Number:
Medical Information		
Physician Name and Phone Number:		Psychiatrist Name and Phone Number:
Dentist Name and Phone Number:		Optometrist Name and Phone Number:
Current Diagnoses:		
Advance Directives(Circle all that apply): Full Code No Code Living Will Power of Attorney		
Immediate Health Care Concerns:		
Personal Contacts		
Family Please list <u>ALL</u> living family members.		
Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	
Name:	Relationship:	Address:
Phone:	Level of Involvement:	

Family (Cont'd)

Name: Relationship: Address:

Phone: Level of Involvement:

Name: Relationship: Address:

Phone: Level of Involvement:

**Friends
(Please list any involved friends)**

Name: Relationship: Address:

Phone: Level of Involvement:

Name: Relationship: Address:

Phone: Level of Involvement:

Name: Relationship: Address:

Phone: Level of Involvement:

Spouse Information

Spouse's Name: Spouse's Date of Birth Spouse's SSN

Current Status: Divorced: Date Deceased: Date

Spouse's Military Service: Branch: Discharge Date: Discharge Status:

Former Spouses:

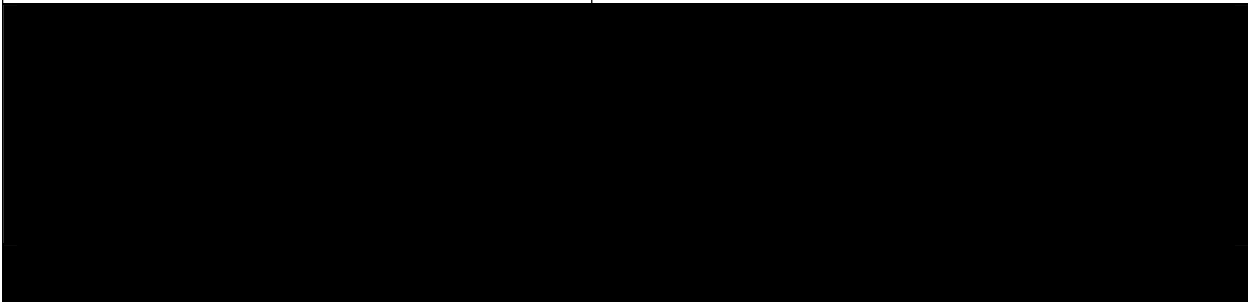
Legal Information

Other advocates currently involved (Circle all that apply):
 Power of Attorney Representative Payee Case Manager/Social Worker Mental Health Clinic
 Attorney Other Personal Representative Other (Please list):

Does the client have a will? Yes No If yes, Will Administrator Name and phone number:

Does the client have a trust? Yes No If yes, Trustee Name and phone number:

Any pending legal action? Yes No If yes, describe:



Insurance Information				
Life Insurance				
Life Insurance? Yes No		If yes, Company Name:		
Phone Number:	Policy Number:	Type of Insurance: Whole-Life Term-Life	Paid in full? Yes No	
Name of Beneficiary:	Address of Beneficiary		Phone Number of Beneficiary:	
Health Insurance				
Medicare: Yes No		Medicare Type (Circle all that apply) Part A Part B Part D		
Medicare Part D Provider (Prescriptions):		Medicare Part D Policy Number:		
Medicare Replacement Insurance: Yes No	Provider:		Policy Number:	
Medicaid: Yes No		Medicaid Member ID:		
Other Health Insurance: Yes No	Company Name:		Policy Number:	
Phone Number:	Address:			
Financial Information				
Income				
Source:	Amount:		Frequency:	
Source:	Amount:		Frequency:	
Source:	Amount:		Frequency:	
Bank Accounts				
Checking Account: Yes No	Bank Name:	Account Number:	Approx. Balance:	Co-Owner:
Savings Account: Yes No	Bank Name:	Account Number:	Approx. Balance:	Co-Owner:
Other Account:	Bank Name:	Account Number:	Approx. Balance:	Co-Owner:
Other Account:	Bank Name:	Account Number:	Approx. Balance:	Co-Owner:
Expenditures				
Rent/Mortgage Paid To:	Average Amount Due:		Due Date:	
Electricity/Energy Paid To:	Average Amount Due:		Due Date:	
Water Paid To:	Average Amount Due:		Due Date:	
Natural Gas/Propane Paid To:	Average Amount Due:		Due Date:	

Expenditures (Cont'd)			
Other Paid To:		Average Amount Due:	Due Date:
Credit Card Paid To:	Current Balance:	Average Amount Due:	Due Date:
Credit Card Paid To:	Current Balance:	Average Amount Due:	Due Date:
Loan Paid To:	Current Balance:	Average Amount Due:	Due Date:
Real Estate			
Address of Property:		Property Type: House Mobile Home Townhouse Other	
Previous Address:			
Mortgage Type:	Balance Owed:	Monthly Payment:	Paid in Full: Yes No
Mortgage Company Name:		Mortgage Company Phone Number:	
Mortgage Company Address:			
Years Owned:	Any Liens? Yes No	Lienholder:	Amount Owed on Lien:
Annual Tax Amount:	Are Taxes Current? Yes No	Back Taxes Owed:	
Funeral/Burial Arrangements			
Funeral Home Name:	Address:	Phone Number:	
Pre-paid Plan or Trust? Yes No	Paid in Full? Yes No	Amount Owed:	
Company Name:		Policy Number:	
Burial or Cremation?	Cemetery Name:	Cemetery Phone Number:	
Own Any of the Following? Plot Vault Headstone Marker	Paid In Full? Yes No	Amount Owed:	
Other Information			
Religious Preference:	Church Preference:	Highest Level of Education:	
Occupation:	Mother's Name:	Father's Name:	

Psychosocial History: (Briefly document family history, educational, occupational, military background, socialization patterns-family, friends, other community supports, etc.)

Psychiatric History: (Briefly document diagnostic history, reason for most recent admission; describe mood, behaviors, substance use history, etc.)

Physical Limitations, if any: (vision, hearing, Dental, speech, nicotine use etc.)

Rationale for why guardianship is necessary for this client: (Briefly document reasons why guardianship is appropriate)