|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 ALL 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)** | | | | | | | | | | | |
|  | | | | | | | | | | | |