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| 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: |
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| **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: |
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| **Psychosocial History: (Briefly document family history, educational, occupational, military background, socialization patterns-family, friends, other community supports, etc.)** |
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| **Psychiatric History: (Briefly document diagnostic history, reason for most recent admission; describe mood, behaviors, substance use history, etc.)** |
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| **Physical Limitations, if any: (vision, hearing, Dental, speech, nicotine use etc.)** |
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| **Rationale for why guardianship is necessary for this client: (Briefly document reasons why guardianship is appropriate)** |
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