Life Essentials Guardianship Program
40 S. Perry Street, Suite 130 Dayton, OH 45402
Telephone: (937) 586-0545 Fax: (937) 586-0565
www.LifeEssentials.org

REFERRAL FORM

FORM MUST BE PRINTED OR TYPEWRITTEN AND ALL QUESTIONS ANSWERED

Referral Date:_____

Referral Agency _____Contact_____
Address_____ Telephone_____Ex_____
City_____ State_____Zip Code_____

Conditions leading to Referral/Purpose of Guardianship:_____
_____

Client Information

Client Name _____Telephone_____
Current Address_____
City_____ State_____ Zip Code_____
Length of time at current address _____
Address prior to admission_____
At time of referral, was client living alone? ☐ Yes ☐ No
Date of Birth_____ Sex_____ Maiden Name_____
Social Security# _____ Marital Status_____ Race_____ Ethnic Origin_____

Income and Assets

(Attach proof or copies of applications for income)

☐ SS ☐ SSI ☐ SSDI Amount _$___
Pension (Name) _____Other (Name) _____

Will ☐ Yes ☐No ☐Unknown Location of Documents_____
Trust ☐ Yes ☐No ☐Unknown Location of Documents_____
Home Owner: ☐ Yes ☐ No Car Owner (Make & Model):_____
Checking Account#_____ Savings Account#_____
Other Assets_____

Insurance

Medicaid #_____Medicare #_____ ☐ A ☐ B
Other Insurance_____ Policy Number_____
MyCare Ohio ☐ Yes ☐ No If Yes, Name of Insurance_____

Military

Veteran ☐Yes ☐ No Military I.D._____
Branch of service_____ Dates of service _____

Spousal Information

Name_____ Maiden Name_____

Address_____ City_____ State_____ Zip_____

Social Security Number_____ Medicare Number_____

Date of Birth_____ If Deceased, Date of Death and Place_____

Source of Income and Amount_____ Veteran/Branch_____

Date Contacted_____ ☐ Agree ☐ Disagree with Guardianship Referral ☐ Not Contacted

Relative/Significant Others (Must include all immediate family members, address and telephone numbers. Attach additional sheets if necessary)

Relative's Name_____Relationship_____

Address_____ City_____ State_____ Zip_____

Telephone home_____work_____ cell_____

Date Contacted_____ ☐ Agree ☐ Disagree with Guardianship Referral ☐ Not Contacted

Relative's Name_____Relationship_____

Address_____ City_____ State_____ Zip_____

Telephone home_____work_____ cell_____

Date Contacted_____ ☐ Agree ☐ Disagree with Guardianship Referral ☐ Not Contacted

Relative's Name_____Relationship_____

Address_____ City_____ State_____ Zip_____

Telephone home_____work_____ cell_____

Date Contacted_____ ☐ Agree ☐ Disagree with Guardianship Referral ☐ Not Contacted

Other Agencies/Social Workers involved in the case_____

Violent threats or actions noted: ☐ Yes ☐ No If yes describe_____

Criminal History (Describe)_____

If there is a discharge plan, please describe:_____

_____

Living Will ☐Yes ☐ No ☐ Unknown

Location of Documents_____

Agent's Name and Contact Information_____

Durable Power of Attorney ☐Yes ☐No ☐ Unknown

Location of Documents_____

Agent's Name and Contact Information_____

Psychiatric Advance Care Directive ☐Yes ☐ No ☐ Unknown

Location of Documents_____

Agent's Name and Contact Information_____

Funeral Arrangements ☐Yes ☐No ☐ Unknown

Funeral Home Name and Address_____

Activities of Daily Living (ADLs)	No Help	Supervise	Hands On	Instrumental Activities of Daily Living (IADLs)	No Help	Supervise	Hands On	N/A
Transfer/Mobility	☐	☐	☐	Medication Administration	☐	☐	☐	☐
Bathing	☐	☐	☐	Shopping	☐	☐	☐	☐
Grooming	☐	☐	☐	Meal Preparation	☐	☐	☐	☐
Dressing	☐	☐	☐	Telephone	☐	☐	☐	☐
Toileting	☐	☐	☐	Arrange Transportation	☐	☐	☐	☐
Eating	☐	☐	☐	Ability to take short walks	☐	☐	☐	☐
Taking Medications	☐	☐	☐	Light Housework	☐	☐	☐	☐
Notes:				Laundry	☐	☐	☐	☐
				Heavy Housework	☐	☐	☐	☐
				Home Maintenance	☐	☐	☐	☐
				Legal/Financial	☐	☐	☐	☐

Hospital Only The following information is required

☐ Admissions Sheet
☐ Statement of Expert Evaluation
☐ If nursing home placement, copy of proof of payment source, application and guarantee
☐ Correspondence sent to family/significant others notifying of referral for guardianship

Nursing Homes/Group Care Facilities Only The following information is required

☐ Admissions Sheet
☐ Statement of Expert Evaluation
☐ Complete Patient Trust Fund Account
☐ Proof of Payment Source (application and payment guarantee)
☐ Correspondence sent to family/significant others notifying of referral for guardianship

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Please completed the attached form when making a referral for guardianship to Life Essentials. Please note the following general information you may find helpful in making your referral.

1. A guardianship referral is not warranted unless you feel an individual is incapacitated and unable to manage his or her own financial resources and/or is unable to make informed medical decisions. Life Essentials requires a referral form to be completed and a Statement of Expert Evaluation signed by proposed ward's doctor/psychiatrist. You may also be asked to submit copies of recent medical records that support what conditions caused a proposed ward to be considered incompetent and /or incapacitated.

2. Family members, if appropriate, have the option to serve as guardian in lieu of a Life Essentials Guardian. We ask that you contact responsible family members regarding the possibility of serving, prior to contacting us.

3. Temporary Emergency Guardianships are appropriate only if "the proposed ward faces a substantial and immediate risk of financial loss or physical harm or needs immediate medical attention and the proposed ward lacks capacity to respond to the risk of loss or harm or to obtain the necessary medical attention"

4. Please provide all requested documentation and any other information you may feel pertinent. All questions must be answered on the referral form. A lack of information will delay the referral process and may result in Life Essentials denying the referral.

5. Once the referral form has been submitted to our office, please keep us informed of any significant changes (i.e. medical condition, residence, family involvement, etc.) regarding the proposed ward.

Thank you for your interest in the welfare of the proposed ward.