Life Essentials
40 South Perry Street
Suite 130
Dayton, Ohio 45402
937-586-0545
937-586-0565 fax

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.

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