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| **GUARDIANSHIP REFERRAL FORM**  |
| **REFERRING INFORMATION** |
| Referring Person’s Name: |
| Referring Person’s Phone: |
| Agency Name: | Fax: |
| Address: | State: | ZIP Code: |
| Agency Phone: |
| Email Address: | Date of Referral: / /  |
| **applicant information** |
| Name: Gender:  |
| Date of birth: / / AGE: | SSN: | Phone: |
| Current address: |
| City: | State: | ZIP Code: |
| **Family Contact Information (INCLUDE ALL)** |
| Relative Name: |
| Address: | Phone: |
| City: | State: | ZIP Code: |
| Relationship: | Last date of contact: / / |
| Relative Name: |
| Address: | Phone: |
| City: | State: | ZIP Code: |
| Relationship: | Last date of contact: / / |
| Relative Name: |
| Address: | Phone: |
| City: | State: | ZIP Code: |
| Relationship: | Last date of contact: / / |
| **DEMOGRAPHICS** |
| Race/Ethnicity:  [ ]  White, Non-Hispanic[ ]  Black, Non-Hispanic[ ]  Native Hawaiian/Other Pacific Islander [ ]  Asian[ ]  American Indian/Native American[ ]  Other | Current marital status:[ ]  Single, Never Married[ ]  Currently Married[ ]  Divorced/Separated[ ]  Widowed[ ]  Currently living with significant other /domestic partner | Children:[ ]  No children[ ]  Have childrenNumber of Children:  |
| Veteran: [ ]  No [ ]  Yes - Discharge Status:  |
| Primary Language: [ ]  Does not speak English |
| Language Proficiency: [ ]  Excellent [ ]  Good [ ]  Fair [ ]  Poor |
| **Provider information** |
| Agency Name: |
| Address: |
| City: State: Zip: |

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| **Income** |
| Source | Monthly Amount | Do you have a representative payee?[ ]  Yes - Name of Rep Payee \_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  No  |
| [ ] Social Security | $ |
| [ ]  SSI/SSDI | $ |
| [ ]  Food stamps | $ |
| [ ]  Employment | $ |
| [ ]  Veterans Benefits | $ |
| [ ]  Owns home/property | $ |
|  [ ]  Investments | $ |
| [ ]  Pension | $ |
| [ ]  Other | $ |
| If applicable, provide address of payee: |
| Other information you would like us to know about your financial situation or concerns: |
| **Insurance Information** |
| Check all that apply: [ ]  Medicaid [ ]  Medicare [ ]  Medicare Part D [ ]  Private [ ]  None |
| Medicaid number: | Medicare number: |
| Supplemental Insurance: | Private Insurance: |
| **Legal Information** |
| Legal guardian/benefactor: |
| Address: | Phone: |
| City: | State: | ZIP Code: |
| Relationship: |
| Do you have: [ ]  Power of attorney [ ]  Living will [ ]  Advance directive [ ]  Irrevocable burial trust |
| **health History** |
| Current incapacitating diagnosis: |  |
| Psychiatric symptoms: |   |
| Physical features: | Eye color:Hair color:Height: Weight: markings: Tattoos/scars/birthmarks  |
| **Consent information** |
| By signing this application, I certify that the information provided is accurate to the best of my knowledge. I understand that providing false information can result in disqualification from the application process or dismissal from Mental health America of Northeast Indiana. |
| Signature of referring agency representative:Printed name: | Date: / / |

4/2017