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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 children  Number 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