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| **Guardianship New Client Assessment**  **Date of Submission:**  |

**THINGS TO KNOW BEFORE FILLING OUT THIS FORM:**

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| **The referral form must be filled out to completion, including any family and income sources.** **The client must be on Medicaid AND receiving Social Security benefits to qualify. Any documentation of the assessments used to establish incapacity should be included with the referral application.** |
| **The Physician’s Orders (PO) statement form provided on MHANI website MUST be signed by a physician.**If someone other than the doctor is filling out the form, the person filling out the form must sign the last section on the last page. The reason for incapacity must be specific to the person and the domains in life affected due to the incapacity. Statements like: IDD or dementia are too vague and will not be acceptable to the court. |
| **Has the residential provider established themselves as Rep Payee?** The Residential Provider should already have established themselves as Financial Representative Payee with Social Security or be in process of doing so.Once we get all the information needed and verified, we will begin the process.It can take anywhere from 6-8 weeks (about 2 months) to gain a Guardianship date on the court docket. |
| **Guardianship is NOT the same as a Power of Attorney**. Guardianship takes away a person’s civil rights. There are less restrictive alternatives to Guardianships that do not take a court appointment process, such as Power of Attorney (POA)/Healthcare Representative/Supported Decision Making/ Financial Representative Payee). These alternatives are only valid if signed, dated, and witnessed by a Notary BEFORE the person lost capacity and able to make an informed decision to choose the individual(s) to act on their behalf. MHANI’s Guardianship Services program does not serve in this capacity.MHANI files as the “Guardian of the person only” as the least restrictive form of guardianship. The petition can also list certain areas that guardianship is needed and serve as a “limited guardianship” based on areas needed the most in the various domains of a person’s life.**Guardianship is established in the same county as the person lives.** MHANI currently has programs in Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, and Whitley counties. **MHANI adopts the Standards & Ethics of the National Guardianship Association.**MHANI Guardianship Program renders guardianship in a person centered, healthcare team approach as much as possible when in the client’s best interests*. The Standards & Ethics of the National Guardianship Association are applied in the context of the Indiana State Law for guardianship.* **GUARDIANSHIP FEES:**There is a **monthly $35 guardianship fee** charged as allowed by the Indiana State Code on guardianship and will be billed for the month that guardianship is established by the court and on-going for every month going forward. |

**Note:** Please fill in all the information requested. Areas marked with an asterisk (\*) are especially important and are required. **Failure to fill in required blanks will delay the referral process.**

|  |  |  |
| --- | --- | --- |
| \*Full legal name of person being referred:  | \*DOB:  | \*Age: |
| \*Social Security Number: | \*Gender:  | \*Race: |
| \*Where does the individual above currently live? (To meet MHANI criteria, the residential placement must have 24/7 staffing).[ ]  Nursing home [ ]  Waiver home [ ]  Group home [ ]  Other – Please specify: |
| \*Name of Current Residential Provider\*Client Admission Date to the current Residential Provider: | \*Address\*Address and phone number of referred person (**IF different from residential provider)**: | \*Phone: |
| Prior Provider: | Address:  | Phone:  |
| **Identification Information:** |  |  |
| Height: | Weight: | Hair color:  | Eye color:  |
| Primary Language: | Form of communication:  |
| Vision: Glasses: | Hearing:  |
| Mobility/Ambulation:  | Comatose: |
| Diet:  |
| Catheter:  |
| Dentures: |
| \*Significant Medical History: |
| \*Preferred Hospital: |
| \*Hospitalizations in the last 90 days (about 3 months) Name of hospital/reason: |

**Healthcare/Medical Providers:**

|  |  |  |
| --- | --- | --- |
| Specialty: | Physician Name: | Phone:  |
|  |  |  |
|  |  |  |
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**\*Care Team of Current Residential Provider/Nursing Facility or hospital care team:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Title | Location | Office phone | Cell phone |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

**\*INSURANCE INFORMATION *-*** Due to MHANI’s use of pro-bono attorneys, this information is needed to establish program criteria. Referral must be connected to a payor source:

|  |  |
| --- | --- |
| \*Medicare #: | \*Medicaid #:  |
| Other insurance: | Social Security Amount (per month): |

**\*INCOME and/or Assets *-*** Due to MHANI’s use of pro-bono attorneys, this information is needed to establish program criteria. MHANI does not have the manpower or resources to liquidate assets.

**Do not leave Blank.**

|  |  |
| --- | --- |
| **Source** | **Amount (per month)** |
| 1. | $ |
| 2. | $ |
| 3. | $ |
| Does the individual have any assets?[ ]  Yes (provide details below) [ ]  No (skip directly to Advance Directive) |
| **Assets** | **Location** | **Value** |
| Real estate |  |  |
| Vehicle |  |  |
| Stocks |  |  |
| Bonds |  |  |
| Annuity |  |  |
| Trust Fund |  |  |
| Checking Accounts |  |  |
| Savings Accounts |  |  |
| Life insurance |  |  |
| Last will |  |  |
| Funeral trust |  |  |
| Burial plot |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Name of person:** | **Phone/Address:** |
| **\*Currently under Guardianship:**  |  |  |
| **\*Financial Representative Payee:** |  |  |
| **\*Power of Attorney:** |  |  |
| **\*Health Care Representative**: |  |  |
| Does the individual have a living will? [ ]  Yes [ ]  NoDoes the individual have an advance directive? ☐ Yes ☐ No |
| Is current residential provider applying to be the Representative Payee? [ ]  Yes [ ]  No |
| Does the individual have end of life wishes? [ ]  Yes [ ]  No |

**What does a meaningful day look like for the individual?**

|  |
| --- |
| Workshop: |
| Day Program: |
| Competitive Employment/Other: |
| Client interests: Current Medicaid Waiver Person-Centered Individual Support Plan (PCISP) including Date : Current Nursing Facility Plan of Care: |

**\*FAMILY: To show the court that due diligence was done & immediate family was notified, it is important to have any family member or community contact listed for the person being referred.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Address** | **Contact #** |
| MOTHER |  |  |  |
| FATHER |  |  |  |
| SIBLING |  |  |  |
| SIBLING |  |  |  |
| SPOUSE |  |  |  |
| CHILD |  |  |  |
| CHILD |  |  |  |
| CHILD |  |  |  |
| CHILD |  |  |  |
| CHILD |  |  |  |
| OTHER |  |  |  |
| OTHER |  |  |  |

**Please include any known Social History:**

**\*INDIVIDUAL CAPACITY:** Completing this information provides a baseline of functionality to allow MHANI to confirm at the face-to-face interview and be sensitive of the time to the individual and care team staff.

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| --- | --- |
|  ***Y/N*** | **Is the person able to:** |
|  | **Communication** |
|  | Communicate verbally (Expressive) |
|  | Communicate with gestures |
|  | Understand what is spoken (Receptive) |
|  | State name |
|  | Respond to name when spoken |
|  | State location |
|  | State date/season |
|  | Follow 1-step directions |
|  | Follow 2-step directions |
|  | Follow complex directions |
|  | Speak 1-word statements |
|  | Speak 2-word statements |
|  | Use complex sentences to express self |
|  | Able to stay with a conversation without getting off track |
|  | Understood only by those who know them well |
|  | Understood by all they interact with |
|  | Write name |
|  | Read name |
|  | Write simple words |
|  | Read frequently used words |
|  | Read complex sentences |
|  | State names of family members |
|  | State names of people common to them on care team |
|  | Recognize familiar people |
|  | Live in the present |
|  | Respond /react to their surroundings |
|  | Identify pain or other health issues |
|  | Track daily routine |
|  | **Physical/Medical** |
|  | Understand the importance of taking medications |
|  | See with or without glasses |
|  | Transfer from sitting to lying down without assistance |
|  | Does person have need of mechanical lift for transfers |
|  | Understand the importance of good hygiene |
|  | Continent of bowel and bladder |
|  | Toilet self and manage all toileting tasks |
|  | **Safety/Welfare** |
|  | Understand personal safety |
|  | Understand consequences of unsafe situations |
|  | Use the telephone to call 911 |
|  | Identify when they are hungry |
|  | Understand importance of good nutrition |
|  | Know the difference between food and non-food items |
|  | Know the need for clothes appropriate for the season/weather |
|  | Identify and adjust temperatures for hot and cold |
|  | **Adult Daily Living Skills** |
|  | Basic home management: dusting, sweeping, mopping etc. |
|  | Appropriately operate appliances to wash, dry, fold, and put away laundry |
|  | **Personal Finances** |
|  | Count bills and coins |
|  | Make purchases at the store without assistance |
|  | Knows the amount and source of personal income |
|  | Ability to defer spending or save for a specific purchase |
|  | **Legal** |
|  | Understand the need for a guardian |
|  | Ability to contact an attorney and request legal advice |
|  | Sign and understand documents if presented to them to give informed consent |
| What is the individual’s level of mobility?[ ]  Walks independently [ ]  Walks with a cane [ ]  Walks with a walker [ ]  Requires a wheelchair |
| Please indicate the appropriate level of the individual’s personal care: Can the individual:[ ]  Pick out own clothes from the closet: [ ]  Independent [ ]  With Cues [ ]  Full Staff Care [ ]  Choose clothes from choice of two outfits: [ ]  Independent [ ]  With Cues [ ]  Full Staff Care[ ]  Staff Chooses Clothes |
| Complete Wash - Upper Body  | [ ]  Independent [ ]  With cues [ ]  Full staff care |
| Complete Wash - Lower Body  | [ ]  Independent [ ]  With cues [ ]  Full staff care |
| Complete-Wash Hair  | [ ]  Independent [ ]  With cues [ ]  Full staff care |
| Complete-Brush Teeth  | [ ]  Independent [ ]  With cues [ ]  Full staff care |
| Complete-Dress Upper Body  | [ ]  Independent [ ]  With cues [ ]  Full staff care |
| Complete-Dress Lower Body  | [ ]  Independent [ ]  With cues [ ]  Full staff care |
| Complete-Comb Hair  | [ ]  Independent [ ]  With cues [ ]  Full staff care |
| **Notes: Please include any additional information not asked for on this form that would assist in MHANI’s processing.** |

**PERSON(s) FILLING OUT THIS FORM MUST SIGN/DATE AND GIVE CONTACT INFORMATION:**

\*Assessor signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*I have read and acknowledge there is a $35 monthly Guardianship Fee associated with MHANI’S Guardianship Services.\*\***

\*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_