



GUARDIANSHIP REFERRAL FORM

SUCCESSOR FORM

For more than 30 years, Mental Health America of Northeast Indiana (MHANI) has served as a professional guardian for adults who need someone to advocate for them and help protect their rights, safety, and well-being. **We provide person-only guardianship**, focusing on each individual's needs, preferences, and quality of life while supporting as much independence as possible.

A successor guardian may be needed when an individual's current guardian is no longer able or willing to serve. **Our program only considers successor guardianship when the current guardian is cooperative and part of the transition.**

BEFORE YOU BEGIN

We know this form is lengthy, but most questions on this form are required in order for us to determine acceptance to our program.

A complete form will expedite the process, helping us avoid follow-up questions and move your referral through the review process more quickly.

This is a fillable PDF. Please complete it electronically by typing directly into the form, then email the completed form to us.

PERSONAL INFORMATION OF PERSON BEING REFERRED

TODAY'S DATE:

Full Legal Name

Date of Birth

Age

Marital Status

Gender

Race

Primary Language

Name of Current Residential Provider

Address of Current Residential Provider

Phone Number of Current Residential Provider

Date of Admission to Current Residential Provider

Facility Contact Person:

Address of Individual (if different from residential provider)

Bed / Room #

Current county of residence:

Type of Residential Placement:

☐

Nursing Home

☐

Waiver Home

☐

Group Home

☐

Other - please specify:

Prior Providers (Name, Address, and Dates)

IDENTIFICATION INFORMATION

Height

Weight

Hair Color

Eye Color

Wears Glasses?

Wears Dentures?

No

No

Hearing Impairment?

Hearing Aid?

No

No

Describe Mobility/Ambulation

Comatose?

No

If yes, since date:

Catheter?

No

If yes, type of catheter:

Describe any diet restrictions

Military Service, Branch, and Dates:

MEDICAL INFORMATION

Primary Diagnosis / Disability / Reason for Guardianship:

HEALTHCARE / MEDICAL PROVIDERS

<u>Physician Name</u>	<u>Specialty</u>	<u>Phone</u>

Preferred Hospital

Significant Medical History

Please list all hospitalizations in the last 90 days, sharing name of hospital and reason for hospitalization

INSURANCE INFORMATION

Medicaid Number

Medicare Number

Other Insurance

Social Security Number

Social Security Amount Per Month

Name of Financial Representative Payee

The Residential Provider should establish as the Financial Representative Payee with Social Security. ***MHANI does not serve in this capacity.***

INCOME / ASSETS

Source

Amount per Month

Source

Amount per Month

Source

Amount per Month

DOES THE INDIVIDUAL HAVE ANY ASSETS? PROVIDE DETAILS BELOW

	LOCATION	VALUE
REAL ESTATE		
VEHICLE		
STOCKS		
BONDS		
ANNUITY		
TRUST FUNDS		
CHECKING ACCOUNTS		
SAVINGS ACCOUNTS		
LIFE INSURANCE		
LAST WILL		
FUNERAL TRUST		
BURIAL PLOT		

FAMILY INFORMATION

	NAME	ADDRESS	PHONE
SPOUSE			
MOTHER			
FATHER			
SIBLING			
SIBLING			
SIBLING			
SIBLING			
CHILD			
CHILD			
CHILD			
CHILD			
OTHER			
OTHER			
OTHER			
OTHER			

REFERRING AGENCY / SOURCE

Referring Agency Name

Name of Person Filling Out Form

Position / Title

Phone Number

Email

Describe your involvement/relationship with the individual:

Are you aware of anyone else who may be willing and appropriate to serve as successor guardian?

No

Please list all known family members, friends, or other individuals who were contacted to serve as successor guardian before seeking MHANI's professional services:

CURRENT GUARDIAN INFORMATION

Is the individual currently under a court-appointed guardianship: ☐ YES ☐ NO

Type of guardianship

- ☐ Person
☐ Estate
☐ Person and estate

Name of Current Guardian or Professional Organization

Phone Number of Current Guardian

Address of Current Guardian

Current Guardian's relationship to Referred Individual

Has the current guardian been contacted about the need for a successor? ☐ YES ☐ NO

What is the current guardian's status? Select the one that applies:

- ☐ Current guardian wishes to resign and will cooperate with the transition
☐ Current guardian is deceased
☐ Other:

Please explain why a successor guardian is being requested at this time

Please describe what will happen if a successor guardian is not appointed

Is there an immediate concern regarding any of the following? Please check all the apply

- ☐ Health or Medical care
☐ Housing / Residential placement
☐ Benefits
☐ Consent for Services
☐ Legal / Court matter
☐ Safety

CURRENT GUARDIAN INFORMATION CONTINUED

Is the individual currently receiving appropriate care and services? ☐ YES ☐ NO

Who is currently making decisions for the individual?

Who will be making decisions for the individual while the successor guardianship is pending?

Does the referred individual currently have a Power of Attorney? ☐ YES ☐ NO

Does the referred individual currently have a Healthcare Representative? ☐ YES ☐ NO

County where guardianship is currently established

Case/Cause number

Date guardianship was established

Date of most recent court report

Has the court been notified that a successor guardian may be needed? ☐ YES ☐ NO

Has the court requested or ordered a successor guardian? ☐ YES ☐ NO

Is there currently a hearing scheduled? ☐ YES ☐ NO

*Please email the Letters of Guardianship, Court Order of current guardianship,
and most recent Court Report with this form.*

ACKNOWLEDGEMENT

By submitting this referral, I certify that the information provided in this referral is true, accurate, and complete. I understand that MHANI will rely on the information provided when evaluating the request to serve as successor guardian.

I understand that MHANI may request additional information or documentation as part of its review and that submission of this referral does not guarantee that MHANI will accept the guardianship.

Signature:

Date:

I understand that Indiana law permits a guardian to receive a \$35 monthly guardian fee. If MHANI is appointed as successor guardian, this fee may be assessed to the individual, as permitted by law and based on the individual's circumstances.

Signature:

CAPACITY

COMPLETING THIS INFORMATION PROVIDES A BASELINE OF FUNCTIONALITY THAT ENSURES
OUR FACE TO FACE ASSESSMENT IS SENSITIVE OF THE TIME TO THE INDIVIDUAL AND CARE
TEAM STAFF

YES NO IS THE PERSON ABLE TO:

☐	☐	COMMUNICATE VERBALLY
☐	☐	COMMUNICATE WITH GESTURES
☐	☐	UNDERSTAND WHAT IS SPOKEN
☐	☐	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
☐	☐	BE UNDERSTOOD BY ALL THEY INTERACT WITH
☐	☐	BE UNDERSTOOD ONLY BY THOSE WHO KNOW THEM WELL
☐	☐	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

CAPACITY CONTINUED

YES	NO	IS THE PERSON ABLE TO:
☐	☐	RECOGNIZE FAMILY PEOPLE
☐	☐	LIVE IN THE PRESENT
☐	☐	RESPOND / REACT TO THEIR SURROUNDINGS
☐	☐	IDENTIFY PAIN OR OTHER HEALTH ISSUES
☐	☐	UNDERSTAND THE IMPORTANCE OF TAKING MEDICATION
☐	☐	SEE WITH OR WITHOUT GLASSES
☐	☐	TRANSFER FROM SITTING TO LYING DOWN WITHOUT ASSISTANCE OR MEDICAL LIFT
☐	☐	UNDERSTAND THE IMPORTANCE OF GOOD HYGIENE
☐	☐	BE CONTINENT OF BOWEL AND BLADDER
☐	☐	TOILET SELF AND MANAGE ALL TOILETING TASKS
☐	☐	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 NEEDS FOR CLOTHES APPROPRIATE FOR THE SEASON / WEATHER
☐	☐	IDENTIFY AND ADJUST TEMPERATURES FOR HOT / COLD
☐	☐	DO BASIC HOME MANAGEMENT: DUST, SWEEP, MOP, ETC.
☐	☐	APPROPRIATELY OPERATE APPLIANCES
☐	☐	COUNT BILLS AND COINS
☐	☐	MAKE PURCHASES AT THE STORE WITHOUT ASSISTANCE
☐	☐	KNOW THE AMOUNT AND SOURCE OF PERSONAL INCOME
☐	☐	DEFER SPENDING OR SAVING FOR A SPECIFIC PURCHASE
☐	☐	UNDERSTAND THE NEED FOR A GUARDIAN
☐	☐	CONTACT AN ATTORNEY AND REQUEST LEGAL ADVICE

CAPACITY CONTINUED

☐	WALKS INDEPENDENTLY
☐	WALKS WITH A CANE
☐	WALKS WITH A WALKER
☐	REQUIRES A WHEELCHAR

PLEASE INDICATE THE APPROPRIATE LEVEL OF THE INDIVIDUAL'S PERSONAL CARE	Independently	With Cues	Requires Full Staff Care
PICK OUT OWN CLOTHES	☐	☐	☐
WASH UPPER BODY	☐	☐	☐
WASH LOWER BODY	☐	☐	☐
WASH HAIR	☐	☐	☐
BRUSH TEETH	☐	☐	☐
DRESS UPPER BODY	☐	☐	☐
DRESS LOWER BODY	☐	☐	☐
COME OR STYLE HAIR	☐	☐	☐