District Three Governmental Cooperative
Guardianship Program
Referral Form

Referral received from: _____ **Date:** _____

Do you and/or your agency have a plan in place to petition the appropriate court to have the Guardianship Program named guardian/conservator of client? ___

****Once a referral is chosen for a vacant slot in the Guardianship Program, the referring person/agency will have *45 days* to submit the necessary information to their attorney in order for the appropriate court to be petitioned. Failure to do so will result in the loss of this slot.****

Client Information:

Name: _____ SSN: _____
(Last) (First) (Middle)

DOB: _____ Age: _____ Sex: _ Race: _____ Religion: _____

Native Language: _____

Permanent Address: _____

Telephone #: _____ Temporary Address: _____

Nature of Incapacity (Include Onset and Duration): _____

_____

_____

Extent Client can care for self: _____

_____

_____

Is there a medical statement or other supporting documentation? _____

If documentation is not attached, when will it be available? _____

Circumstances of referral and investigative findings: _____

_____

Mental/Psychiatric Health History: _____

_____

Client Name: _____
Last First

Medical History: _____

_____

Educational/Vocational History: _____

_____

Legal History (if known): _____

List all family members/persons involved:

Name Relationship Address/Telephone

Family History:

Client's Financial Information:

Source of Income Amount

Total monthly income:

Checking Account Number Institution Balance

Client Name:

Last First

Savings Account Number Institution Balance

Other Account Type Institution Balance

Real Property Owned:
Approximate Value:

Other Pertinent Information:

Client Name: _____

Last First

Referral Received by: _____ **Date:** _____
Presented to Panel, Referrals, and Screening Subcommittee on: _____
Eligible: YES NO (Circle One)

COMMENTS: