



Guardianship Referral Form

Client Name: _____ Date of Referral: _____

Referring Agency: _____

Contact Person: _____ Relationship: _____

Phone Number: _____ Email: _____

General Information

Home Address: _____

Status of Home: Own ___ Rent ___

Living Alone? Yes ___ No ___

Marital Status: Married ___ Divorced ___ Separated ___ Never Married ___ Widowed ___

Nursing Facility: _____ Date of Admission: _____

Date of Birth: _____ Place of Birth: _____

Social Security #: _____ Medicare #: _____

Medicaid ID #: _____ Medicaid Case #: _____

Describe the client's ability to communicate: _____

Medical Information

Physician's Name and Phone #: _____

Psychiatrist's Name and Phone #: _____

Dentist's Name and Phone #: _____

Optometrist's Name and Phone #: _____

Current Diagnosis (Please attach current History and Physical report): _____

Advance Directives: Full Code ___ No Code ___ Living Will ___

Any immediate health care concerns? Explain: _____

Personal Contacts

Please list any and all family members:

Name	Relationship	Address	Phone #	Level of Involvement
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Please list any involved friends:

Name	Address	Phone #	Level of Involvement
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Spouse Information

Spouse's Name: _____ Social Security #: _____

Current status: ___ Divorced (Date): _____ ___ Deceased (Date): _____

Spouse's Date of Birth: _____

Military Service: Yes ___ No ___ Branch: _____ Discharge Date: _____

Former Spouse(s): _____

Legal Information

Does this person currently have any form of advocate? (Power of Attorney, Healthcare Representative, Representative Payee, Guardian?) Yes ___ No ___

(Please list or include copies of any documentation pertaining to this.) _____

Does the client have a will? Yes ___ No ___ Name of will holder: _____

Any pending legal action? Yes ___ No ___ Please describe: _____

Life Insurance

Life Insurance: Yes ___ No ___ Company Name: _____

Phone #: _____ Policy Number: _____

Type of Insurance: Whole Life ___ Term Life ___ Paid in full? Yes ___ No ___

Name of Beneficiary: _____ Address: _____

Phone #: _____

Health Insurance

Medicare: Yes ___ No ___ Type: Part A ___ Part B ___ Part D ___

Medicare Part D Provider: _____ Policy #: _____

Medicare Replacement Insurance: Yes ___ No ___

Provider: _____ Policy #: _____

Medicaid: Yes ___ No ___ Caseworker's Name: _____ Phone #: _____

Other Health Insurance: Yes ___ No ___ Company Name: _____

Policy #: _____ Phone #: _____

Address: _____

Financial Information

Monthly Income: (ex: SSA, SSI, SSDI, Pension, etc.)

Amount: _____ Source: _____

Amount: _____ Source: _____

Amount: _____ Source: _____

Bank Account: Yes ___ No ___ Name of Bank: _____

Address: _____ Phone #: _____

Checking Account: Yes ___ No ___ Account #: _____

Savings Account: Yes ___ No ___ Account #: _____

Resident Account: Yes ___ No ___ Account #: _____

Other (list): _____ Relevant Info: _____

Other (list): _____ Relevant Info: _____

Current Debts and Creditors:

Rent: \$ _____ Mortgage: \$ _____ Utilities: \$ _____

Loans: \$ _____ Other: \$ _____

Credit Cards: \$ _____ Credit Card Company(s): _____

Real Estate

Please complete this section only if the client owns real estate

Address of Property: _____

Property Type: House ___ Mobile Home ___ Other ___

Previous Address: _____

Mortgage Type: Traditional ___ Reverse ___ Balloon ___

Mortgage Paid in Full? Yes ___ No ___ Total Owed \$ _____ Monthly Payment: \$ _____

Mortgage Company Name: _____

Address: _____ Phone #: _____

Years Owned: _____ Are there any liens against the property? Yes ___ No ___

Lien Holder: _____ Amount Owed \$ _____

Are taxes current? Yes ___ No ___ Back Taxes Owed: \$ _____

Funeral/Burial Arrangements

Funeral Home: _____ Address: _____

Phone #: _____ Fax #: _____

Pre-Paid Plan or Trust: Yes ___ No ___ Paid in full ___ Amount Owed: \$ _____

Company Name: _____ Policy #: _____

Burial ___ Cremation ___ Cemetery Name: _____ Phone #: _____

Own Plot? Yes ___ No ___ Paid in full ___ Amount Owed: \$ _____

Location of Plot: _____

Own Vault? Yes ___ No ___ Paid in Full? Yes ___ No ___ Amount Owed: \$ _____

Own Headstone? Yes ___ No ___ Paid in Full? Yes ___ No ___ Amount Owed: \$ _____

Own Marker? Yes ___ No ___ Paid in Full? Yes ___ No ___ Amount Owed: \$ _____

Other

Religious Preference: _____

Church Preference: _____

Education: 8th Grade or Less ___ 12th Grade or Less ___

High School Graduate ___ Post High School Degree ___

Other Pertinent Information

Why is guardianship being pursued? _____

Please provide any additional information that may be useful in determining whether this client is eligible for Guardianship services through Thrive Alliance: _____

Please return this referral along with a completed Physician’s Statement confirming the incapacity of the referred person to:

Thrive Alliance, Attn: Guardianship Services
2158 Cottage Ave
Columbus, IN 47201
Phone: 812-314-2785 Fax: 812-372-7846