# Guardianship Information Form

(Fill out completely, DO NOT LEAVE BLANKS, attach additional pages as needed)

## REFERRAL INFORMATION

APS Referral: Y __ N ___
If not APS, Referral Source: ______________________________ Date: ______________
Referral/APS worker Name:_____________________________ Phone #:______________
Information Provided By: ___________________________ Phone #: ______________

## INFORMATION ON INDIVIDUAL BEING REFERRED FOR GUARDIANSHIP

Last Name: ______________ First: __________________ Middle: ________________
SS#: _______________ Place of Birth: __________________ Date of Birth: _________
Ethnicity: _____ Gender: ___ Marital Status: ____ Spouse Name: ________________
Medicaid #: ________________________________ Effective Date: _________________
Medicare #: ________________________________ Effective Date: _________________
Religious Preference: ______________ Attend Church Y __ N __ Where: _______

## LEGAL STATUS

Reason for Guardianship Referral: ____________________________________________
______________________________________________________________________________
Is individual a Resident of KY as defined by KRS 210.290(2)(a): Y ___ N ___
Disability/Adjudication Determination Date: _________ County: __________________
Guardian Appointment Date: ___________ County: ___________ Case #: __________
Current Guardian (if successor requested): __________________ Phone # __________
Address ______________________ City _______________ State _______ Zip Code ________
Criminal History: Y ___ N___ If yes, list charges/convictions: ___________________
______________________________________________________________________________
______________________________________________________________________________

## PLACEMENT

Current Placement: __________________________________ Phone: ______________
Level of Care: _________________________________ Admission Date: ___________
Address: _________________ City _______________ State _______ Zip code ________
Does individual receive waiver services? (if yes circle what applies)
SCL Michelle P ABI acute ABI long term HCB
Waiver Case Manager Name: _________________________ Phone #: ___________
List anything staff should be aware of when visiting individual, i.e. behaviors, threats, conditions: _______________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Submit completed form to**:
Department for Aging and Independent Living
Division of Guardianship Attn: Referral
275 E Main St., 3 E-F
Frankfort, KY 40621

**FAMILY RELATIONSHIPS** (parents, **include mother's maiden name**, siblings, spouse, children, grandchildren, etc)

| Relationship | Name | Address | Phone |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**OTHER OPTIONS EXPLORED**, State Guardianship is by statute the last resort, list all other options tried and exhausted, including less restrictive means of providing for the individual (Power of Attorney, Health Care Surrogate) and individuals capable of being guardian.

| Less Restrictive option | Individual acting on behalf | Relationship | Address | Phone # |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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**MEDICAL**

Diagnosis: Intellectual Disability: ____________________________________

Mental Illness: ____________________________________

Physical Conditions: ____________________________________

Allergies: ____________________________________

Adaptive Equipment: ____________________________________

Does the individual have a Living Will? Y____ N ___ Date Executed: ___________

Advanced Directive?: Y__ N __ Date Executed: ______________________

Do Not Resuscitate Order (DNR)? Y ___ N __ Date Executed: _______________

End of Live Wishes? ____________________________________

(Attach copies of advance directives, living will, DNR, end of life wishes)

| Relationship | Name | Address (street, city, state, zip code) | Phone # |
|---|---|---|---|
| Attending Physician | | | |
| Current Psychiatrist | | | |
| Health Care Surrogate | | | |
| Case Manager | | | |
| List Others as Needed | | | |

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**MEDICATIONS:** list below or attach current list

| Medication Name | Reason prescribed | Prescribing Physician | Dosage and Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**PHYSICAL CHARACTERISTICS:**

Height: ________ Weight: _________ Eye Color: __________ Hair Color: _______
Distinguishing Marks (tattoos, scars, birthmark, etc.): _________________________

______________________________________________________________________

**RISK FACTORS**

Medical: _________________________ Physical: ___________________________
Mental Health: ____________________ Criminal History: ______________________
History of violent or acting out Behavior: ___________________________________
Other: ____________________________________________________________________

**FINANCES/INCOME/ASSETS:** (Provide description, location, assessed value of all income and assets. Include copy of deeds, policies, and documents)

**Owns Real Estate:** Y __ N __ PVA Value: ___________ Mortgage: Y __ N __
Address of Property: _________________ City _______ State _______ Zip code ________
Mortgage Company: ______________________________ Account #: _______________
Address of Mortgage Company: ____________ City _______ State _____ Zip code ________
Is property occupied? Y __ N __ If yes, by whom? _________________________
If multiple real estate holdings provide the above information for all properties.

**Bank Accounts:** Include last three (3) months of statements

| Account Type | Balance | Account # | Bank/Broker | Address | Phone |
|---|---|---|---|---|---|
| Savings Account | | | | | |
| Checking Account | | | | | |
| Certificate of Deposit | | | | | |
| Stocks/Bonds | | | | | |

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| Safety Deposit Box | Key location | | | | |
|---|---|---|---|---|---|
| Other | | | | | |

Identify purpose/restriction on accounts such as burial savings, joint accounts, etc.

______________________________________________________________

______________________________________________________________

**Income/Assets:** (Social Security, SSI, Veteran's, Black Lung, Pension, Railroad Retirement, other)

| Benefit | Claim # | Amount | Payee | Relationship | Phone |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
| | | | | | |
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Other assets (including personal property)? ______________________________

______________________________________________________________

______________________________________________________________

**INSURANCE:**

Medical Insurance Company: ____________________ Phone #: ____________
Policy #: ____________________________ Location of Policy: ____________
Life Insurance Company: ______________________ Phone #: ____________
Policy #: ______________ Face Value: __________ Cash Value: ___________

List any other insurance including Home Owners, Vehicle, etc. Including name of company, type of insurance, policy # and phone #:

______________________________________________________________

______________________________________________________________

**BURIAL:** Attach any burial contracts

Prepaid Burial? Y __ N __ Where? ______________________________
Primary Contact for Arrangements: ____________________ Phone #: ________
Funeral Home Preference: _________________________ Phone #: ________
Address: ____________________ City __________ State __________ Zip code ________
Prearranged Cemetery: ______________________________________
Phone #: ________________________ Deed/Plot: ______________________
Address: ____________________ City __________ State __________ Zip code ________
Preferred Cemetery: ____________________________ Phone #: __________
Address: ____________________ City __________ State __________ Zip code ________

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