Jewish Family and Community Services Guardianship Referral Form

Date of Application _____

1. IDENTIFYING INFORMATION

Consumer Name _____ County of Residence _____

D.O.B. _____ Gender: _____ Social Security Number: _____

Current Address:

_____

Current Phone:

_____

Height: _____Weight: _____ Hair Color: _____ Eye Color: _____

Contact

Residential Service Provider_____ Phone

_____

Contact

Day Program (if applicable) _____ Phone

_____

2. PRESENTING PROBLEMS/NEED FOR GUARDIANSHIP

Briefly Describe:

_____

_____

_____

_____

Has There Been Any Previous Adjudication For Incapacitation / Incompetency? Yes/No

If Yes, Briefly describe including date(s) if known: _____

_____

_____

_____

_____

3. PERSONAL DATA

Marital Status: _____ Date: _____

Education Level: _____ Occupation: _____

History of Forensic Involvement: Yes/No
Veteran: Yes/No
Blind: Yes/No
Deaf: Yes/ No
Religion: _____

Most Recent State Facility Stay:

_____

Place of Birth: _____ Mother's Maiden Name: _____

Father's Full Name:

_____

Friends/Relatives Involved:

_____

Name Relationship Telephone

_____

Name Relationship Telephone

_____

Name Relationship Telephone

_____

Name Relationship Telephone

_____

Name Relationship Telephone

4. REFERRAL SOURCE

Name of person filling out referral:

_____

Supports Coordinator: _____ Phone #:

_____

Agency, Organization: _____ Cell #: _____

5. MEDICAL INFORMATION

Diagnosis (DSM IV): _____

Date of Last Psychiatric Evaluation:

_____

Last Psychological Evaluation:

_____

Medical Conditions (e.g. diabetes, heart condition):

_____

_____

_____

Current Medications: *** ATTACH ADDITIONAL SHEETS IF NEEDED ***

_____

Name of Medication Reason Prescribed

_____

Name of Medication Reason Prescribed

_____

Name of Medication Reason Prescribed

_____

Name of Medication Reason Prescribed

_____

Name of Medication Reason Prescribed

_____

Name of Medication Reason Prescribed

_____

Name of Medication Reason Prescribed

Allergies:

_____

_____

Primary Medical Doctor: _____ Telephone:

_____

Primary Psychiatrist: _____ Telephone: _____

Other Doctors Involved with Consumer:

_____

Name Telephone

_____

Name Telephone

_____

Name Telephone

Most Recent Psychiatric Admission:

_____

Name of Institution

Date of Hospitalization:

_____

6. HEALTH INSURANCE

Private Insurance (name): _____ Policy #: _____Active ? _____

Medicare (policy #):

_____

Medical Assistance (name and policy #):

_____

Other Insurance:

_____

7. FINANCIAL / LEGAL

Source of Income Amount Frequency

Employment: _____ _____

Social Security: _____ _____

SSI: _____ _____

SSD: _____ _____

Food Stamps: _____ _____

Monthly Living Expenses Amount Frequency

Rent: _____ _____

Mortgage: _____ _____

Utilities: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Other known expenses: (e.g. spend money, bus pass, food allowance)_____

_____

_____

Income Producing Assets: (including CD's, Property, Life Insurance)

Value Account # Name of Financial Institution

Savings Account: _____ _____ _____

Checking Account: _____ _____ _____

Burial Account: _____ _____ _____

Life Insurance: _____ _____ _____

Cert. of Deposit: _____ _____ _____

Other: _____ _____ _____ _____

Does the consumer currently have a Representative Payee? Yes/No

_____

Name Address Telephone

Does anyone currently have Power of Attorney? Yes/No

_____

Name Address Telephone

Last Will and Testament:

_____

Living Will:

_____

Power of Attorney:

_____

Burial Plans:

_____

_____

_____

_____

Other Legal Concerns:

_____

_____

_____

8. GUARDIANSHIP

1. Type of Guardianship being sought:

Estate: _____ Limited Estate: _____

Person: _____ Limited Person: _____

2. Physician who will testify: _____ Phone: _____

Physician or person completing referral form:

_____

Name:

_____

Address:

_____

_____

Phone Numbers:

_____

Please fax or email referrals to: Nicole Iole, Director of Guardianship Program at JFCS

Fax referrals back to: 412-345-0380

Email referrals to: niole@jfcspgh.org

Call to set up a referral meeting after faxed or emailed. Thank you.

412-977-6322 or 412-422-7200