

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 Community Based Services
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 #

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			

Submit completed form to:
 Department for Community Based Services
 Division of Guardianship Attn: Referral
 275 E Main St., 3 E-F
 Frankfort, KY 40621

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					

Submit completed form to:
Department for Community Based Services
Division of Guardianship Attn: Referral
275 E Main St., 3 E-F
Frankfort, KY 40621

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

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 _____

Submit completed form to:

Department for Community Based Services
 Division of Guardianship Attn: Referral
 275 E Main St., 3 E-F
 Frankfort, KY 40621